

# Strengthening Consumer Protection:

Priorities for Health Care Workforce Regulation

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Taskforce on Health Care  
Workforce Regulation

October 1998



*Pew Health Professions Commission*



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# Executive Summary

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## CRITICAL ISSUES FACING HEALTH PROFESSIONS REGULATION

Health care workforce regulation plays a critical role in consumer protection. For most of this century, the state regulation of health care occupations and professions has established a minimum standard for safe practice and removed the egregiously incompetent. As market and regulatory forces shape the future of health care, particularly the location and content of practice, the structures and functions of state professional regulation must continue to provide consumers with important protections leading to safe and effective practice.

This ostensible goal of professional regulation—to establish standards that protect consumers from incompetent practitioners—is eclipsed by a tacit goal of protecting the professions' economic prerogatives. This dichotomy of goals has created serious shortcomings that include limited public accountability, support for practice monopolies that limit access to care and lack of national uniformity. These shortcomings are further exacerbated by the current changes in health care.

To become a viable element of consumer protection in health care, professional regulation must demonstrate that it unequivocally serves the public good. This will require that it evolve at the same rate as the economic, political, intellectual and technological environments in which its licensees work. In this context of consumer protection, regulators, legislators, policy makers and health care professionals face three priority areas that present the most challenges to, and promise for, improving professional regulation: health professions boards and governance structures, scopes of practice authority, and continuing competence.

## REGULATORY BOARDS AND GOVERNANCE STRUCTURES

Key to the current professional regulatory scheme is the professional board. With few exceptions, an individual and independent board is established for each regulated profession in each state. Although charged with consumer protection and despite open meeting laws, board processes are generally unknown to the public. At a time of increasing demands for credible and accountable consumer protection, some fear that boards may become relegated to a sideline role in shaping public policy that serves consumer interests.

There is little coordination of effort among the individual boards or among the states. This lack of coordination, particularly at a time of technological and marketplace change, produces discordant results such as underused professionals, competition for scopes of practice, limited professional mobility, and restricted access to care. Furthermore, in an era when information is crucial to public safety and effective markets, boards are insufficiently equipped and financed to collect, manage and publish information that would be useful to the public.

#### SCOPES OF PRACTICE AUTHORITY

The legal authority to provide and be reimbursed for health care services is tied to state statutes generally referred to as practice acts, which establish professional “scopes of practice.” These practice acts, often different from state to state, are the source of considerable tension among the professions; the resulting “turf battles” clog legislative agendas across the country. Caught in the middle of these battles, legislators must decide whether new or unregulated disciplines and occupations should be regulated and whether professions currently regulated should be granted expanded practice authority.

These battles are costly and time-consuming for the professions and for the state legislators involved. The more critical problem, however, is the decision-making process itself which is distorted by campaign contributions, lobbying efforts and political power struggles. In this environment, practice act decisions may not be based on evidence regarding quality of care and the potential impact on health care costs and access. Such decisions (regarding who can competently provide what types of care) demand a more empirical foundation and a less political venue.

#### CONTINUING COMPETENCE

Ensuring the competence of health care professionals throughout their careers is a persistent challenge to both public and private sectors. Few would disagree with the assessment that it is possible for a practitioner’s competence to diminish years after initial licensure and that continuing education credits do not guarantee competence. Although some of the allied health professions boards (e.g. physician assistants and emergency medical technicians) do



require periodic demonstrations of competence as conditions of continued licensure, most of the health professions boards (including boards of medicine, nursing and pharmacy) do not.

The monumental shift to new reimbursement and delivery structures has highlighted quality of care issues. Underlying managed care's critics and legislative restraints is the concern that high quality health care – and a professional's competence to provide it – may suffer from too much attention on reducing costs. Requiring demonstrations of competence during professionals' careers could shift attention to the quality of care delivered to patients and clients.

Legislatures have not allowed or required regulatory boards to play a role in requiring continuing competence demonstrations of their licensees throughout their careers. The private sector has been far more active in this arena. Voluntary professional associations and private certification and credentialing boards have established and continue to perfect standards, goals and evaluation measurements to meet the demands for competence throughout one's professional practice. These models are good starting points but will need additional development. In addition, the role of the private sector can only go so far. Practitioners whose credentials are not routinely reviewed by private systems may fall through the cracks without attention by the states.

#### A FUTURE VISION OF HEALTH CARE WORKFORCE REGULATION

The Pew Health Professions Commission envisions a future regulatory system for the health professions that will undergo the following transformations to better serve the public interest:

A move towards national standards – Health care workforce regulation, along with education and credentialing, is moving in the direction of national standards. This national uniformity may be led by the federal government, agreements among the states or national professional associations. For regulation, the most dramatic effect will be standard scopes of practice authority and continuing competence requirements for each profession across the country.

Significant overlap of practice authority among the health professions – Driven by the professions, new information and technologies, and innovation in the workplace, traditional boundaries – in the form of legal scopes of practice – between the professions have blurred.

This trend will continue to pressure the regulatory system to accommodate the demand for flexibility while ensuring that the public's safety is protected. Decisions regarding scopes of practice and continuing competence requirements therefore must be based on comprehensive evidence regarding the accessibility, quality and cost-effectiveness of care provided to the consumer.

New venues and participants for regulatory policy-making – The representation of various parties at health care decision-making tables is changing. Legislatures may not be the best venue to decide technical professional matters as lobbying, campaign contributions and allegiance to constituents often distort rational policy development. A more impartial venue with increased representation of interested parties, particularly consumers of health care services, will better support regulatory policy-making that is accountable, balanced and based on empirical evidence.

Integration of regulatory systems that protect health care consumers – Efforts to regulate health care plans, care delivery sites and health care professionals historically have been independent, both within and across states. This lack of coordination and integration among systems has resulted in inefficiencies and inadequate protection of the public. For example, poor coordination restricts practitioners who might competently provide care, particularly across state borders. Poor coordination also allows incompetent practitioners to move from health plan to health plan and from state to state. Today's market trends to integrate the various regulatory and delivery systems will mean that health professions regulation will be scrutinized and evaluated for its strengths and weaknesses with an eye toward consolidating systems where appropriate to better serve the public.

Increased regulatory focus on quality of care and competence assurance – Concerns over market forces in health care illuminate the need to strengthen all means of ensuring consumer protection. The resulting integration of regulatory entities and increased consumer participation in policy making will contribute to regulations that emphasize quality assurance, continuing competence demonstrations, and cooperation among the professions.

## SUMMARY OF RECOMMENDATIONS

❖ *Indicates a legislative implementation template in Appendix A*

Here, the Pew Commission focuses on three issues of critical importance identified in the 1995 report: professional boards and governance, scopes of practice authority and continuing competence. These three issues generate the most controversy and present the most challenge to crafting improvement in professional regulation.

### REGULATORY BOARDS AND GOVERNANCE STRUCTURES

**Recommendation 1** Congress should establish a national policy advisory body that will research, develop and publish national scopes of practice and continuing competency standards for state legislatures to implement.<sup>1</sup>

❖ **Recommendation 2** States should require policy oversight and coordination for professional regulation at the state level. This could be accomplished by the creation of an oversight board composed of a majority of public members or it could become the expanded responsibility of an existing agency with oversight authority. This policy coordinating body should be responsible for general oversight of that state's health licensing boards and for assuring the integration of professional regulation with other state consumer regulatory efforts (e.g. health facility and health plan regulation).

**Recommendation 3** Individual professional boards in the states must be more accountable to the public by significantly increasing the representation of public, non-professional members. Public representation should be at least one-third of each professional board.<sup>2</sup>

<sup>1</sup> Commissioner Graham abstained from voting on this recommendation.

<sup>2</sup> While all of the Commissioners support this recommendation, some Commissioners also support these configurations for boards: 1) 50 percent public membership; 2) public member majorities; or 3) one-third public members, one-third health care professionals, and one-third other representatives (e.g. other licensed health care professionals, hospital and health plan administrators, health services researchers).

**Recommendation 4** States should require professional boards to provide practice-relevant information about their licensees to the public in a clear and comprehensible manner. Legislators should also work to change laws that prohibit the disclosure of malpractice settlements and other relevant practice concerns to the public.

**Recommendation 5** States should provide the resources necessary to adequately staff and equip all health professions boards to meet their responsibilities expeditiously, efficiently and effectively.

**Recommendation 6** Congress should enact legislation that facilitates professional mobility and practice across state boundaries.

#### SCOPES OF PRACTICE

**Recommendation 7** The national policy advisory body recommended above should develop standards, including model legislative language, for uniform scopes of practice authority for the health professions. These standards and models would be based on a wide range of evidence regarding the competence of the professions to provide safe and effective health care.

**Recommendation 8** States should enact and implement scopes of practice that are nationally uniform for each profession and based on the standards and models developed by the national policy advisory body.

❖ **Recommendation 9** Until national models for scopes of practice can be developed and adopted, states should explore and develop mechanisms for existing professions to evolve their existing scopes of practice and for new professions (or previously unregulated professions) to emerge. In developing such mechanisms, states should be proactive and systematic about collecting data on health care practice. These mechanisms should include:

- Alternative dispute resolution processes to resolve scope of practice disputes between two or more professions;
- Procedures for demonstration projects to be safely conducted and data collected on the effectiveness, quality of care, and costs associated with a profession expanding its existing scope of practice; and
- Comprehensive legislative “sunrise” and “sunset” processes that ensure consumer protection while addressing the challenges of expanding existing professions’ practice authority, and regulating currently unregulated healing disciplines.

#### CONTINUING COMPETENCE

- ❖ **Recommendation 10** States should require that their regulated health care practitioners demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their careers.

# I Prologue

## THE WORK OF THE PEW HEALTH PROFESSIONS COMMISSION

This latest work on professional regulation by the Pew Health Professions Commission began in early 1997. This report builds upon the Commission's 1995 report of the Taskforce on Health Care Workforce Regulation, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. That report proposed ten broad recommendations for improving workforce regulation in the public's interest (Finocchio et. al., 1995). Over a year of debate and discussion followed with responses to the recommendations and policy options. Formal responses were captured in *Considering the Future of Health Care Workforce Regulation* (Gagnola and Stone, 1997).

The Pew Commission encouraged the second Taskforce to be bold and visionary, producing work that would be a catalyst for change. Specifically, the Pew Commission charged this taskforce to:

*Envision a future health professions regulatory system that meets consumers' reasonable expectations of access to comprehensive, appropriate, cost-effective and high quality health services and to explore ways to move the current system toward this future system.*

Here, the Pew Commission focuses on three of the ten issues identified in the 1995 report: professional boards and governance, scopes of practice authority and continuing competence. These critical issues generate the most controversy and present the most challenge to crafting improvement in professional regulation. This report presents these three issues in light of current social, economic and political realities, offers recommendations and rationale for future improvement, and reviews relevant activities and examples from around the country.

## II Introduction

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### THE CHALLENGE OF CONSUMER PROTECTION

The Pew Commission believes that an improved regulatory future will be built on the existing strengths of state-based professional regulation. However, regulation's many weaknesses must be diminished or removed in order to strengthen consumer protection. The overall purpose of this report is to improve professional regulation's role in meeting consumers' expectations for expanded choice of high quality and safe practitioners. Specifically, this report focuses on professional regulatory boards, continuing competence and scopes of practice authority, areas that the Pew Commission believes present the most challenges to, and most promise for, improving professional and occupational regulation.

Consumers expect access to high quality, affordable, effective and safe health care from a range of providers and competent practitioners. The epic changes in the health care marketplace present new challenges for purchasers, consumers and regulators to meet these expectations. As market-based approaches to managing the health care system predominate and continue into the future, government will continue to enact laws that set minimum standards for public safety and remedy market failures. This tension between market and regulatory forces is reshaping consumer protection laws and agencies, fostering an expanded use of information, and promoting the role of the consumer in making choices about health care.

In the marketplace, purchasers of care are using their buying power to promote cost-effectiveness. Both purchasers and consumers are relying on empirical measures to judge health plans and practitioner quality and performance. In the regulatory arena, laws shaping the health care system are rapidly changing. Federal lawmakers are debating and passing legislation on access to and quality of care in managed care organizations. Consumer "Bills of Rights" have been introduced in many state legislatures and in Congress (Moran, 1997). State governments are also working to integrate the regulation of managed care corporations, health insurance and health facilities (Health Policy Tracking Service, 1998).

Another state regulatory institution—health professional licensure—plays a critical role in consumer protection. Licensure is a state privilege bestowed upon a profession that enables it

to self-regulate through educational standard setting and peer discipline. For most of this century, state regulation of health care occupations and professions has established minimum standards for safe practice and removed the egregiously incompetent.

This ostensible goal of professional regulation—to establish standards that protect consumers from incompetent practitioners—is eclipsed by a tacit goal of protecting the professions’ economic prerogatives. This dichotomy of goals has created serious shortcomings that weaken the states’ effectiveness as strong and unbiased consumer protection advocates. These weaknesses have been well documented and analyzed in reports and studies over the past 25 years (*please see the chronological bibliography in the references section*). A brief summary of these shortcomings is provided here:

- Although the professions need to guide their respective boards, professional dominance on boards limits public accountability and can promote self-interest in policy making;
- Some scopes of practice conferred upon licensed occupations and professions are unnecessarily monopolistic, thereby restricting consumers’ access to other qualified practitioners and increasing the costs of services;
- Although a practitioner’s competence is evaluated upon initial entry into a licensed profession, current state requirements do not assess or guarantee continuing competence;
- Although several professions and states have made progress, national standards for entry to practice, professional mobility, scopes of practice, continuing competence, and discipline are limited;
- Consumers’ efforts to make informed decisions about practitioner competence are hindered by the poor quality and limited quantity of information that boards release regarding licensees; and
- Professional regulation is not sufficiently integrated or coordinated with other public and private consumer protection structures and processes.



Because the current changes in health care have exacerbated these shortcomings, many state agencies and individual boards are building upon existing strengths to remedy weaknesses. As market forces shape the future of health care, the structures and functions of state professional regulation, and the importance of professionalism, will continue to provide consumers with important protections from unsafe, unethical and ineffective practitioners. However, to become a viable element of consumer protection in health care, professional regulation must demonstrate that it unequivocally serves the interests of the public over those of the professions.

The Pew Commission believes that professional regulation in every state must evolve at the same rate as the economic, political, intellectual and technological environments in which its licensees work. In the paragraphs that follow, this changing environment is briefly described.

#### PROFESSIONAL REGULATION IN A CHANGING ENVIRONMENT

The way health services are provided by practitioners is being transformed by health plans and hospitals concerned with controlling costs (Hafferty and Light, 1995). Schneller and Ott (1996) note that, “Hospitals, HMOs, and those who represent patients are in a position to shift the balance of power and clinical roles among the different health care occupations and professions.” These efforts result in substitutions between similar professionals, demands for multi-skilled workers, and the use of alternative and complementary treatments and practitioners. In addition, the increasing use of information technologies is reducing the hierarchical relationships between professions. The often exclusive privilege of specific professions to diagnose, treat and perform procedures is opening up and being shared by several professions.

Technologies are continually changing care delivery. Telehealth or telepractice, the interaction between provider and patient across distances using an electronic modality, is used by many health professions, particularly medicine and nursing (Brineger and McGinley, 1998). Currently, telepractice is limited in scope to “virtual” office visits, consultations between practitioners, and some minor procedures, but the future may

expand its use in other settings (such as school clinics or long-term care facilities), locations (across the entire continent or world) and in other forms (such as diagnostic software where no practitioner is actually involved).

Each state uses different criteria to delineate who can provide health services within its boundaries, resulting in a patchwork of 50 slightly different standards for each licensed profession. Telepractice has no geographic boundaries and therefore interstate electronic practice must contend with a dizzying array of rules and regulations. Although some states and professions have made headway in standardizing regulations, no national standards address interstate practice, information exchange, or discipline. Legislators and regulators must address the inevitability of electronic practice – in all of its potential forms – in a way that maximizes access for consumers, ensures quality practice, and provides redress for substandard care and products.

Biomedical research has vastly expanded the understanding of disease but today's practitioner can be overwhelmed with new knowledge, procedures and treatments such as gene therapies, microsurgery, and thousands of new drugs. The current regulatory system does not ensure consumers that practitioners have kept up with the rapidly changing medical literature and are competent to use these new technologies and treatments. Regulators, purchasers and the professions are grappling with appropriate means to assess and ensure that practitioners can safely and effectively utilize their knowledge, judgment and skills over their practice lifetime.

Finally, consumers want the freedom to select their health plans, practitioners and treatment options based on quality and personal beliefs. Already, consumers are purchasing health care from a range of places and practitioners including nutrition stores, weight management services, complementary therapies, and spiritual healing. Information about practitioner competence and treatment options is essential to enable consumers to make safe and effective choices about their care. In a market system where informed decisions are crucial, legislators and regulators will have to focus on collecting and providing relevant practitioner information to consumers. This will require public and private sector collaboration.

## PRINCIPLES FOR HEALTH CARE WORKFORCE REGULATION

The Pew Commission's first Taskforce on Health Care Workforce Regulation articulated five principles upon which state-based regulation should be based to serve the public good (Finocchio, 1995). In its continuing work, the Pew Commission and second Taskforce have used the same principles to inform and direct their deliberations. The Pew Commission believes that state-based health care workforce regulation will best serve the public by:

- Promoting effective health outcomes and protecting the public from harm;
- Holding regulatory bodies accountable to the public;
- Respecting consumers' rights to choose their health care providers  
from a range of safe options;
- Encouraging a flexible, rational and cost-effective health care system  
which allows effective working relationships among health care providers; and
- Facilitating professional and geographic mobility of competent providers.

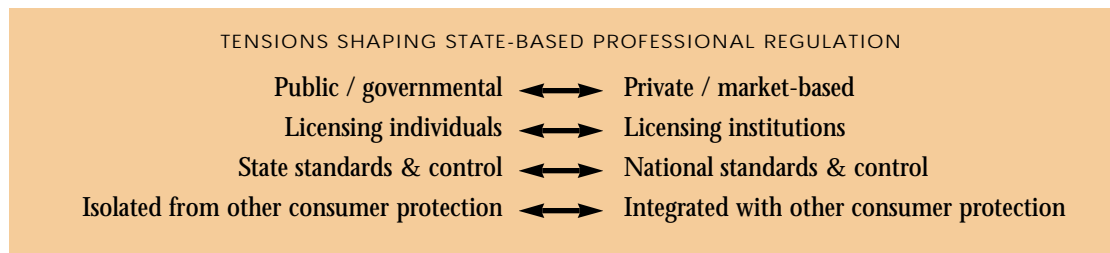
The Pew Commission acknowledges that states do not regulate all health care professions and occupations, and those that are regulated are not done so in a consistent manner across states. The principles above should also apply to unregulated professions and occupations and how they are educated, certified and utilized across delivery sites and states. While this report does not directly address the private-sector contributions to standard setting and competence certification it encourages future cooperation between the public and private sectors.

## A FUTURE VISION OF HEALTH CARE WORKFORCE REGULATION

Determining the exact nature and structure of health care workforce regulation in the future is indeed a challenge, and many outcomes are possible. Options for regulation in the next century range from continuing our state-based, professionally dominated system to one where licensed private institutions would be responsible for deciding who may provide what services. Other possibilities include a "title protection" system, in which titles are separated from scope of practice authority as has been done in Ontario, Canada.

The future might even see initial state licensure based on broad core competencies shared by several disciplines, with specialized private certifications added to individual scopes of practice throughout one's professional career.

Each of these models has its own strengths and weaknesses and the Pew Commission doubts that any one of them alone will concretely describe regulation in the future. The different elements of regulation—individual licenses, practice authority, continuing competence, and discipline—will undoubtedly be shaped by several tensions as regulation transforms to meet a changing environment. These tensions are illustrated below.



The Pew Commission expects to see an approach to regulating health care professionals that combines various elements into a system that is part governmental, with increasing participation of private sector institutions and of consumers. This emerging system is likely to support national standards in some arenas of health professions regulation (practice authority for example) while remaining at the state level for others (complaint and discipline processes that can best be administered and responsive to consumer needs locally). Key components of this transformed system include:

A move towards national standards—Health care workforce regulation, along with education and credentialing, is moving in the direction of national standards. This national uniformity may be led by the federal government, agreements among the states or national professional associations. For regulation, the most dramatic effect will be standard scopes of practice authority and continuing competence requirements for each profession across the country.

Significant overlap of practice authority among the health professions—Driven by the professions, new information and technologies, and innovation in the workplace, traditional boundaries—in the form of legal scopes of practice—between the professions

have blurred. This trend will continue to pressure the regulatory system to accommodate the demand for flexibility while ensuring that the public's safety is protected. Decisions regarding scopes of practice and continuing competence requirements therefore must be based on comprehensive evidence regarding the accessibility, quality and cost-effectiveness of care provided to the consumer.

New venues and participants for regulatory policy-making – The representation of various parties at health care decision-making tables is changing. Legislatures may not be the best venue to decide technical professional matters as lobbying, campaign contributions and allegiance to constituents often distort rational policy development. A more impartial venue with increased representation of interested parties, particularly consumers of health care services, will better support regulatory policy-making that is accountable, balanced and based on empirical evidence.

Integration of regulatory systems that protect health care consumers – Efforts to regulate health care plans, care delivery sites and health care professionals historically have been independent, both within and across states. This lack of coordination and integration among systems has resulted in inefficiencies and inadequate protection of the public. For example, poor coordination restricts practitioners who might competently provide care, particularly across state borders. Poor coordination also allows incompetent practitioners to move from health plan to health plan and from state to state. Today's market trends to integrate the various regulatory and delivery systems will mean that health professions regulation will be scrutinized and evaluated for its strengths and weaknesses with an eye toward consolidating systems where appropriate to better serve the public.

Increased regulatory focus on quality of care and competence assurance – Concerns over market forces in health care illuminate the need to strengthen all means of ensuring consumer protection. The resulting integration of regulatory entities and increased consumer participation in policy making will contribute to regulations that emphasize quality assurance, continuing competence demonstrations, and cooperation among the professions.

#### HOW LEGISLATORS CAN USE THIS REPORT

The Pew Commission acknowledges the challenge of reforming a complex system. With this report it hopes to provide legislators and regulators with a tool and resource to understand and shape professional regulation so that it meets evolving consumer protection needs. The report outlines a future vision of the fundamental structures and processes of state-based professional regulation: boards and governance, scopes of practice and continuing competence requirements. The coverage of topics in this report should not be interpreted as an implication that other topics, such as professional discipline, are any less important today than when identified in the 1995 report. The Pew Commission encourages and applauds efforts to improve disciplinary processes and all other aspects of health professions regulation. The recommendations presented here are the building blocks for a transformed regulatory framework.

It is the Pew Commission's expectation that the recommendations targeting state legislators and regulators will be considered and implemented before those targeting the Federal government, such as the establishment of a national public-private policy body. In Appendix A of this report, the Pew Commission offers legislative implementation templates for several of their recommendations in key state policy areas as a stimulus and blueprint to move the regulatory system toward the envisioned future. Legislators and their staff should consider and shape these legislative templates in the context of their own state's existing health policies, health care needs and consumer expectations. Appendix B includes an overview of recent activity exemplifying the volume of regulatory reform efforts in the ten areas identified by the Pew Commission in the 1995 report as important.

### III Regulatory Boards and Governance Structures

*Organizing the structure and functions of regulatory boards to better serve the public*

#### CURRENT ISSUES

In December 1995, the Taskforce on Health Care Workforce Regulation wrote that regulatory boards were neither sufficiently accountable to the public nor equipped to accomplish their broad objectives. The Taskforce recommended structural changes in board membership, public oversight and increased financial support from the legislature (Finocchio et. al., 1995). This recommendation and its accompanying policy options generated considerable controversy among professional associations and regulators (Gragnola and Stone, 1997). Some legislative activity also occurred over the past three years (*see sidebar*).

Since that recommendation was made, the health care environment continues to present significant challenges to boards. These include new health care delivery and reimbursement structures, telemedicine and other emerging technologies, and innovative use of health professionals. Regulatory structures and functions must transform to address issues of limited public participation and professional accountability, information management and accessibility, and policy coordination among professions and among states.

The piecemeal and narrowly focused nature of state professional boards may marginalize them in today's health care evolution.

#### Activity addressing professional board governance structure

- Oregon – Proposed legislation would have required each licensing board to have at least three (out of seven) public members (H 2296, 1997).
- Colorado – Five newly created mental health professional boards – psychology, social work, marriage and family therapy, professional counselors and one for unlicensed psychotherapists – all have public member majorities (Colorado Revised Statutes, article 43 of title 12. 1998).
- California – In its 1997 sunset report, the California Board of Podiatric Medicine recommended that it have a majority of public members (California Board of Podiatric Medicine, 1997). Although the effort did not succeed, the president of the board, a former California Assemblyman, and the former executive director of the California Board of Medicine, support public majorities (Arnett and Presley, 1998).
- Minnesota – Senate File 2380 would create a temporary Occupational Regulatory Coordinating Council to recommend how a permanent council would address issues of new occupations, structural

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reforms for existing regulation, and state practice acts (Minnesota Board of Examiners for Nursing Home Administrators, 1998). An existing but informal Council of Boards may take on this charge from the Senate Subcommittee on Occupational Regulation.

- Allied health – The National Commission on Allied Health recommended that states increase public representation on individual licensing boards to at least 50 percent (U.S. Department of Health and Human Services, 1995).
- Maine – A report to the Governor and Legislature recommended the establishment of an advisory federation of boards (Kany and Janes, 1997).
- Florida – Although it did not pass, the Senate Committee on Health Care voted to introduce legislation (Senate Bill 256, 1998) to create five new disciplinary boards in five health service areas. There would have been at least three consumer members on each board. The function of these boards would have been to make a determination of the existence of probable cause in health care professional disciplinary cases and to advise the Secretary of the Department of Health on disciplinary matters (Florida Senate Health Care Committee, 1997).

For example, determinations about practitioner competence, quality assurance, and consumer protection policy are evolving without the collaboration of boards. Board insularity can be attributed, in part, to a structure of professional dominance and limited effective participation from public members. Despite open meeting laws, board processes are generally unknown to the public. Many state legislatures and boards have recognized the importance and positive contribution of public membership and participation, but efforts to increase public membership remain limited.

In an era when information is crucial for public safety and effective markets, boards are insufficiently staffed and financed to collect and manage information on behalf of the public. Complete information about practitioners, particularly substandard ones, is still not easily available to the public in all but a few states. Moreover, boards have not made much progress enforcing laws requiring hospitals to report sanctioned practitioners (Cohen and Swankin, 1997). In California,

for example, the medical board has characterized hospitals' lack of compliance on reporting as a "near crisis" (Medical Board of California, 1995).

Collaboration among individual boards in most states remains minimal. This lack of coordination produces discordant results such as underused professionals, competition for scopes of practice, and restricted access to care (*see the chronological bibliography in the*



*references section*). Such matters of broad state health policy—cost, quality, safety and accessibility of care—tend to be outside the purview of individual boards but few, if any, states have examined the overall impact of regulating each profession separately. While some states have developed mechanisms for inter-board cooperation and policy development, they are limited in number and strength.

In addition to this limited *intrastate* coordination, there is little *interstate* coordination in key policy areas. These areas include sharing disciplinary information, scope of practice consistency and continuing competence standards. The increasing presence of multi-state integrated delivery systems and telepractice and other technologies have made political boundaries obsolete. Poor interstate regulatory coordination limits the mobility of competent practitioners and access to care through technology.

At a time of public concern over consumer protection in managed care, some fear that professional boards may become relegated to a sideline role in shaping health policy that serves consumer interests, particularly in the areas of practitioner competence and quality assurance (Andrew and Sauer, 1996). An important role remains for state-based licensure boards but they must evolve in responsive and innovative ways. The recommendations presented below offer an opportunity for professional boards to make meaningful contributions to consumer protection, and to shape a high quality, cost effective and accessible health care system.

#### RECOMMENDATIONS FOR REGULATORY BOARDS AND GOVERNANCE STRUCTURES

**Recommendation 1** Congress should establish a national policy advisory body that will research, develop and publish national scopes of practice and continuing competency standards for state legislatures to implement.<sup>1</sup>

Brennan and Berwick (1996) contend that regulation is disconnected from the best available scientific knowledge about quality and its sources because, “An empirical,

<sup>1</sup> Commissioner Graham abstained from voting on this recommendation.

scientific foundation for the improvement of regulation does not yet exist.” This disconnect with empirical rigor is exacerbated by the multiplicity of practice acts, continuing competence requirements and other rules and regulations that exist in each state for each profession.

A national policy advisory body established by Congress would focus on developing an unbiased empirical rigor in two areas of professional regulation that suffer the most from poor standardization, lack of evidence and turf battles between the professions. These two areas are scopes of practice authority and standards for continuing competence determination. Other policy issues on which this body might perform research and analysis would include professional mobility, data collection, sharing and transfer of data and standards, and public access to the National Practitioner Data Bank.

This policy advisory body would examine and compare education and training standards between the professions, compare practice acts across the states, and collect and analyze evidence about quality of care and practitioner competence (*see recommendation seven, page 27*). With this, and potentially other evidence and expert testimony, the advisory body would write practice authority acts for each profession. These standard practice authority acts would be disseminated as templates for use by state legislators and ultimately become recognized and adopted by all the states.

The structure of this new national policy advisory body may resemble the now-defunct Office of Technology Assessment and might be sited in a currently existing agency of the federal government (such as the Agency for Health Care Policy Research or the Bureau of Health Professions). Alternatively, it may be contracted under charter with a private non-profit organization such as the Institute of Medicine in the National Academy of Sciences. In either scenario, it should have representation and input from relevant stakeholders such as hospitals and health plans, health professional associations, consumer organizations, health services researchers, federations of state regulatory boards, and the state and federal governments.

It is important to note that this body will only function in an advisory capacity to Congress, to relevant Federal agencies such as the Health Care Financing Administration,

and to state legislators, regulatory agencies, and professional boards. It would not be empowered to promulgate regulations.

❖ **Recommendation 2** States should require policy oversight and coordination for professional regulation at the state level. This could be accomplished by the creation of an oversight board composed of a majority of public members or it could become the expanded responsibility of an existing agency with oversight authority. This policy coordinating body should be responsible for general oversight of that state's health licensing boards and for assuring the integration of professional regulation with other state consumer protection regulatory efforts (e.g. health facility and health plan regulation).

❖ *See legislative implementation template in Appendix A.*

The laws governing the professions are not coordinated around any explicit health policy or consumer protection objectives. Currently, most states have not established forums for such policies – the cost, quality, safety, and accessibility of health care – to be decided in a broadly interdisciplinary and accountable manner. Individual professions now operate with separate governance structures and standards even though they practice together in the same state, at the same health care institutions, and serve the same populations of patients. The current regulatory system is perceived to protect and promote professional self-interest rather than advancing a strong consumer agenda.

Furthermore, the regulation of people and the regulation of institutions have developed autonomously and remain poorly coordinated. Effective working relationships are needed between all public regulatory agencies and private oversight mechanisms such as the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance. In today's environment of heightened scrutiny of market and regulatory forces and their impact on consumer protection, an opportunity is afforded to legislators to coordinate lawmaking.

A collective and unbiased policy making forum is needed to examine broad health and consumer protection policy issues and establish policy in the context of current health care, economic, political and social realities. For example, an unbiased oversight forum would make decisions on collaborative practice issues where two or more professions are involved. A coordinated approach to consumer protection would also assure that boards standardize their programs and performance objectives in areas such as information dissemination, investigation and discipline, and demonstrations of continuing competence. Regulatory oversight and coordination would also integrate professional regulation with other public and private consumer protection institutions and activities.

Establishing effective and accountable oversight and coordination will be challenging. The Pew Commission proposes two means: 1) a publicly dominated oversight board or council; or 2) centralized administrative oversight by an executive agency branch or office. Legislators in each state will weigh the advantages and disadvantages of each option and decide which would be most effective. In either case, oversight and coordination in the public interest will need to meet the following objectives:

- Establishing, measuring and evaluating performance objectives for individual professional boards, particularly in the areas of continuing competence assessments, investigation of complaints and discipline;
- Ensuring consistency and uniformity of regulatory processes and outcomes by centrally reviewing and approving rules, regulations and other initiatives by individual boards that may affect more than one profession;
- Ensuring policy coordination between individual licensing boards that is not addressed by the work of the national policy advisory body;
- Ensuring coordination between licensing boards and other state and federal agencies, particularly consumer protection agencies;
- Establishing criteria for the appointment of board members and implementing effective education and training programs for all members and staff;

- Establishing programs and criteria for releasing practice-relevant information about licensees to the public; and
- Establishing incentives for effective enforcement including budget review and approval.

States may choose to accomplish these objectives by establishing a new board. This body should be consumer-dominated and include representation from care delivery organizations, payers, consumer advocates, legislators, and other state consumer protection agencies. Representatives of the professions would hold a minority of seats. The chairperson should be a consumer member of the board.

Some states already have centralized administrative agencies for licensure or consumer protection but rarely do they have the powers described above. States that wish to accomplish these oversight and coordination functions through an existing agency will need to enact laws expanding the powers and responsibilities of centralized licensing agencies or other agencies such as state departments of health.

States will face a number of challenges when establishing a new oversight board or empowering an existing centralized agency. In both scenarios, the legislature will have to delegate policy making to this entity. An oversight and coordination body that is solely advisory will not have the power to accomplish the functions set forth above. This delegation of powers from the legislative to the executive branch of government may be complex. Legislators should look to successful examples of such power delegation between branches for guidance.

Also in both scenarios, legislators should ensure that the oversight entities are not assigned authority over boards' day-to-day operations and should not serve as an appeals venue in the investigation and discipline process. An oversight body or agency should not "micro-manage" or duplicate the work of individual boards, but rather establish and enforce overall policy goals. Additionally, any new body or centralized agency will need to have adequate resources and experienced staffing to carry out its responsibilities (*see recommendation five, page 18*).

Finally, legislators face the challenge of establishing oversight leadership that is representative and unbiased. In those states where an oversight board is established, the

board membership and chairperson selections will be subject to the same appointment process politics as individual boards. While oversight by a centralized agency will have qualitatively different and less direct consumer stewardship than the oversight board (by virtue of its membership and chairperson), its accountability will be similar to the operation of any state cabinet-level department whose leader is appointed by the governor. See the template in Appendix A for more information and guidance for writing relevant legislation.

### Recommendation 3

Individual professional boards in the states must be more accountable to the public by significantly increasing the representation of public, non-professional members. Public representation should be at least one-third of each professional board.<sup>2</sup>

State licensure boards have struggled with the fact that the professions themselves dominate regulation's public purposes. Yessian and Greenleaf (1997) write that, "...professionals, because of their expertise and political influence, exert continuing influence in ways that bias the efforts towards their own interests, with little countervailing influence by consumer-biased interests."

If professional regulation is to objectively serve consumer protection and broader health policy goals, participation from those stakeholders with public safety, health policy and economic interests must be included. Moreover, structural changes and external incentives are needed as self-regulating professions rarely initiate improvements in consumer protection that threaten their economic interests and professional sovereignty (Brennan and Berwick, 1996).

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<sup>2</sup> While all of the Commissioners support this recommendation, some Commissioners also support these configurations for boards: 1) 50 percent public membership; 2) public member majorities; or 3) one-third public members, one-third health care professionals, and one-third other representatives (e.g. other licensed health care professionals, hospital and health plan administrators, health services researchers).

To ensure this credibility with the public, the membership structure of individual professional boards must include increased public, non-professional membership with no close familial or fiduciary connections to any regulated licensee. Public representation should comprise at least one-third of members on any board. Legislators should ensure that all board members undergo training before their tenure begins to prepare them for their role as consumer protection regulators. Public members, in particular, must have training to allow them to be as effective as possible in a highly technical and complex environment (Citizen Advocacy Center, 1995). The appointment process for professional and public members to all boards must be as free as possible of politics and cronyism to ensure better objectivity and accountability (Relman, 1997).

#### Recommendation 4

States should require professional boards to provide practice-relevant information about their licensees to the public in a clear and comprehensible manner. Legislators should also work to change laws that prohibit the disclosure of malpractice settlements and other relevant practice concerns to the public.

For regulation to support the market's strengths and remedy its failures, consumers need information. This requires creating, processing and providing the information necessary to facilitate an efficient and safe marketplace (Jost, 1997). For example, the reporting of sentinel events (such as adverse outcomes) in hospitals is an increasingly important measure of performance used by administrators, regulators, purchasers and consumers. Currently, there is little coordinated management and dissemination of information about professional practice and safety from discrete sources.

The public purpose of boards will be strengthened only if public representation is combined with significant public access to information about licensees. All boards should make publicly available licensee profiles that include such information as education, private certifications, continuing competence assurances, disciplinary actions and sanctions taken by the board, hospital or workplace, criminal convictions and malpractice settlements.

For this to happen, legislators will have to rescind other laws that restrict boards from revealing information such as criminal convictions and malpractice settlements. Without such legislation, consumers may not have critical information they need to determine a practitioner's competence. At the same time, reasonable protections of practitioner confidentiality (as in some cases of chemical dependency) should be respected.

These profiles should be made readily available through multiple means, such as the Internet, toll-free numbers and annual summary reports in public libraries. Furthermore, information about practitioners, particularly their malpractice settlements, should be explained both in a context of malpractice generally, and by specialty group specifically. For example, in Massachusetts, physician profiles that include any malpractice payments are put in statistical context of "below average, average, and above average" (Massachusetts Board of Registration in Medicine, 1998).

#### **Recommendation 5**

States should provide the resources necessary to adequately staff and equip all health professions boards to meet their responsibilities expeditiously, efficiently and effectively.

Boards have not been provided the resources, personnel nor technologies to meet their responsibilities effectively (Relman, 1997). Compared to Medicare Physician Review Organizations (PRO) that focus on only a subset of physicians, state medical boards have far fewer resources with which to accomplish their objectives. In Georgia, for example, the medical board's budget in 1995 was \$819,000 (Federation of State Medical Boards, 1995). The same state's PRO budget (in 1997) was over \$3 million (Health Care Financing Administration, 1997). This ratio – almost four to one – is similar in eight other states.

Board members themselves are poorly compensated given the amount of challenging work they are expected to perform. In Colorado, each board member receives only \$50 per meeting, hearing or examination attended. The original act establishing this compensation amount has not changed in over 18 years (Colorado Revised Statutes, subsection 13 of section 24-34-102, 1998). Moreover, it has been estimated that board members spend twice



as much uncompensated time preparing for the actual compensated time they spend in meetings and hearings (Douglas, 1998). And, some states do not pay boards members at all.

The funding challenge for boards revolves around two important issues: 1) licensing fees; and 2) boards' control over these fees. Boards generally rely on licensing and relicensing fees to carry out their duties and in many states, these licensing fees are insufficient to support all of a board's activities. Typically, a board spends the lion's share of its resources on disciplinary investigations and legal services for prosecution.

These fees are established by legislatures and influenced by professional associations and societies. For example, when the Medical Board of California proposed a fee increase to expand investigations and discipline, the California Medical Association successfully lobbied to have the measure abandoned (Bernstein, 1998).

The amount of resources provided to boards by legislative appropriation may be less than the amount generated by fees. Legislators may direct collected fees initially to a state's general fund that is then subject to budget battles, appropriations and spending caps. Consequently, a board may be given fewer resources than it could have collected and spent directly as cash fees from licensees.

For boards to better serve the public, states should appropriate and authorize a sufficient amount of funds if fees are routed into the general fund. This may require that legislators exempt professional boards from budget spending caps. Legislators may also allow direct collection and spending of licensing fees, allowing boards to raise fees and spend additional revenues as approved by an oversight entity. Additionally, states should consider alternative funding sources such as a health plan per capita assessment to increase the amount of resources at their disposal.

#### **Recommendation 6**

Congress should enact legislation that facilitates professional mobility and practice across state boundaries.

As health care markets become national, a federal role in consumer protection is more warranted. Federal involvement in professional regulation (such as PROs and

re-certification proposals) have been justified when state governments or private initiatives have not offered satisfactory public protection or controls on cost increases (Yessian and Greenleaf, 1997).

Telepractice is a compelling justification for a more centralized and better integrated regulatory system as practitioners can “virtually” practice across physical and political boundaries and may pursue a career in several states. Current state licensure laws do not facilitate interstate movement or telepractice; nor do they offer sufficient redress to consumers in the event of substandard telepractice from outside their jurisdiction (Western Governors’ Association, 1998).

Recently, the National Council of State Boards of Nursing endorsed a mutual recognition model for interstate nursing practice (National Council of State Boards of Nursing, 1997). This will involve a complex interstate compact that allows a nurse’s license to be recognized by participating states. Although encouraging, this undertaking only deals with mobility at a multi-state level for one profession.

A federal law would preempt state laws that erect barriers to effective telepractice and mobility across political boundaries within the United States. State laws that restrict practice by those from another state generally serve narrow economic interests of the professions to limit competition from other practitioners. This federal law should respect the states’ rights to license and discipline individual practitioners while ensuring that a license from one state is recognized in another.

There is legitimate concern, however, that telepractice could make it difficult for a consumer to file a complaint and pursue disciplinary recourse in the event of substandard care. Tort law in the state where the practitioner engaged in telepractice—in other words, where the patient receiving services resides—should apply even when the practitioner resides in another state. State boards should be equally vigilant in taking disciplinary action against their licensees regardless of where the harmed patient resides. The federal government could play an instrumental role in holding individual states accountable for accessible, fair and expeditious complaints and disciplinary structures and processes.

## IV Professional Practice Authority

*Determining which health care practitioners are permitted to provide what services*

### CURRENT ISSUES

The recommendation regarding practice authority in the 1995 report, *Reforming Health Care Workforce Regulation* generated considerable controversy. Based on the formal responses submitted regarding the report, this recommendation received one of the highest scores for level of concern and was also one of the most challenged (Gagnola and Stone, 1997).

Despite the 1995 recommendation, the processes by which professional practice authority acts are determined have not changed. Legislative calendars across the country continue to be flooded with bills that would regulate emerging health professions or change the practice authority of currently regulated professions. In 1995, over 800 such bills were considered and approximately 300 laws passed (Fox-Grage, 1995). Two years later, 1600 bills were introduced and about 300 laws enacted (Health Policy Tracking Service, 1997).

This legislative activity is just one component of “turf battles,” the apparently inevitable fights between the professions over who can provide what services. Often lost in the battles between the professions is consumer protection, regulation’s ostensible primary purpose. The potential benefits and dangers to the public from any proposed change are difficult to determine as each party brings to the dispute arguments that embrace the “public’s interest.”

State legislators seeking to answer the health care consumers’ concerns may begin by asking two questions before addressing the merits of any proposed change: First, *who* should determine professional practice authority? Second, *how* should the decision-making be accomplished? In other words, are state legislators the most appropriate experts and are state legislatures the best setting for resolving such technical questions as whether optometrists should be allowed to treat glaucoma; or whether nurse practitioners are qualified to prescribe pharmaceuticals?

An inherent clash of values frames these questions. State legislation values local representation and accountability to constituents, public debate and political compromise. In contrast, today’s consumers and providers are operating in regional or national health care markets that increasingly value customer access and choice, collaboration among

practitioners, cost-effectiveness and quality grounded in evidence. The challenge to state legislators is to incorporate—or at least acknowledge—these contemporary values and standards into their decision-making about practice acts.

Consumer access and choice—At a minimum, consumers want access to competent health care practitioners and the ability to choose among many types of health care practitioners. Consumers also want to be assured that their choices are at least safe, and preferably effective as well. The public has a reasonable expectation that their health care practitioners, whether selected by the consumer or assigned by the health care provider or plan, are competent to provide the care that they are providing. Finally, consumers and purchasers are increasingly aware of health care costs and demanding value for their dollars, while at the same time wary of health care systems that substitute less expensive workers for their higher paid counterparts.

Balancing these tensions between free choice and protection from harm forms the core of the legislator's charge. State legislators try to achieve this balance by establishing and revising practice acts through normal legislative processes. Practice act decisions benefit from the strengths of state legislative activity and suffer under the shadows of partisan politics, campaign contributions and professional lobbying. Critics charge that the outcomes may not always be in the public's best interest:

*Narrow scope of practice, restrictive reimbursement standards, and other legal barriers may limit access to care for large numbers of Americans. In the absence of a national commitment to universal health insurance, the potential for non-physician practitioners to supply much-needed, general health services at reasonable costs should not be ignored (Sage and Aiken, 1997).*

Sharing practice authority among the health professions—It is not only the interests of the public that the state legislator must consider when facing a bill to establish or change a practice act. Health care professionals themselves have additional and conflicting interests. While the professions have an interest in minimal restrictions, they also benefit from the

anti-competitive aspects of regulation. It is always the professions – never the public or consumer advocates – who request regulatory changes to practice acts.

However, the health professions do not act in concert in this arena. Partly because of the current regulatory scheme itself, with its separate and often exclusive scopes of practice, each profession sees itself as proprietary owner or manager of a given territory. Some of the grants of authority have been extremely liberal, resulting in expansive practice acts such as that for physicians; others are extremely restrictive. Requests for changes by one profession are viewed as expansions, encroachments, and infringements by another. Every proposal must end in a win for one side and a corresponding loss for the other. In recent years, increased competition, driven by workforce oversupply and by new employment models within managed care systems, has exacerbated these inter-professional practice battles.

Due to different educational and regulatory histories, the various professions are uniquely situated and view regulation and potential changes differently. Medicine is the only profession with state practice acts that cover *all* of health care services. With this exclusivity, little or nothing exists that can be added to the medical act and medicine has no incentive to delete anything. From this position, medicine can see every request for regulatory change from any other profession or occupation as a challenge or confrontation. With all-inclusive practice authority, the profession also has the credentials, expertise and political influence to comment on potential impacts of changed laws on patients, clients and consumers.

A number of professions that provide some or many of the same services as physicians (for example, nurse practitioners, physician assistants, certified nurse midwives, certified nurse specialists, certified registered nurse anesthetists and optometrists) have spent considerable amounts of time and money in recent years bolstering requests to change their practice acts to permit them to provide care that is consistent with their education and training. Virtually every request has been opposed by organized medicine, often by state medical licensing boards, and sometimes by other professions as well. The outcomes of these requests vary by profession, by year, and by state.

Some of the allied health professions and occupations, and some of the previously unregulated “alternative” and “complementary” professions, have pursued regulation and accompanying subsets of the medical practice acts. Virtually every pursuit has been opposed by at least one other profession. The outcomes of these pursuits vary by profession, by year and by state. Other professions and occupations have declined to pursue regulation.

This fragmented, competitive and adversarial regulatory activity ignores the fact that clinical practice is no longer based on exclusive professional or occupational domains. Collaborative teams of health care practitioners who often share some elements of practice authority are more the rule than the exception in today’s health care systems.

Today’s practitioners, administrators and consumers are increasingly comfortable with the principle that if someone is competent to provide a health service safely, and has met established standards, then he or she should be allowed to provide that care and be reimbursed for it, even

#### Scope of Practice Decision-Making Activity

*Colorado*—With the enactment of House Bill 1072 (1998), the State of Colorado recreates and restructures its mental health boards and the practice laws that apply to unlicensed psychotherapists and to licensed psychologists, social workers, marriage and family counselors, and professional counselors. With the new law, title protection is afforded to the licensed groups but none has an exclusive practice authority. No part of the law creating one profession can be construed to prevent members of the other professions from rendering services within their defined scope of practice. Nothing in any of the licensing laws for the four licensed professions can restrict the practice of unlicensed psychotherapists from practicing as long as they are “listed” with the State Grievance Board. Moreover, all five professions are subject to uniform requirements in terms of 23 prohibited acts, such as sexual contact with patients (Colorado Revised Statutes Title 12, Article 43, 1998).

if that care was historically delivered by members of another profession (*see sidebar*). Nurse practitioners, physician assistants, pharmacists and midwives for example are providing health care that was in the exclusive domain of physicians a few years ago.

The adversarial system for determining practice authority also ignores the natural evolution of professions, and individuals within the professions, as they develop their education, training and accreditation standards to meet the changing needs of patients and clients.

Uniformity among the states—Individual state legislators in separate state legislatures are at a disadvantage in a world increasingly

driven by regional, national and global economies and information systems. This is no less true for decisions regarding health care practitioners than for decisions regarding telecommunication, commerce and aviation industries. With recent developments in telepractice and widespread use of the Internet, the contrast between technological evolution and the relative stagnation in health professions regulation has been sharpened.

Many of the professions have adopted national standards for examination, certification and accreditation. For example, medical specialty board credentials are national and can be carried with one upon moving to a new state. However, practice acts are still decided at the state level with little or no coordination. The differences among practice acts for single professions vary in magnitude. Some are trivial; others are significant (Dower et. al., 1997). For some professions, practice is legal and recognized in some states but illegal in others (Cooper and Stoflet, 1996).

The benefits and necessity of many aspects of state policy-making and policy-enforcement are numerous. However, differences from state to state in practice acts for the health professions no longer make sense.

Finding the evidence to support changes in practice authority – Few would oppose the idea that if certain professionals are found to be competent to provide a service, they should be allowed to do so. Legislators considering practice authority laws must face the following and more challenging question: how must a profession, or a subset of a profession, demonstrate competence?

Mindful of ensuring that the quality of health care is not compromised, decision-makers would optimally look to empirical evidence, and evidence alone, when considering the establishment or change in any practice authority legislation. This evidence would consider objective data regarding outcomes, quality, cost-effectiveness and access. It would be relied upon to determine whether the petitioning profession had demonstrated that its members were competent to provide the health care services in question.

However, evidence of competence in today's legislative activities is only one of many factors that influence the debate. Campaign contributions and lobbying efforts are also

### Estimating the Costs of Battling for Turf: Eye Care in California

A four-year dispute between ophthalmologists and optometrists over who could treat certain eye diseases with what medications in California reportedly cost over \$1.8 million in campaign contributions alone to state legislators (Lucas, 1996).

part of legislative reality. The inherent conflict of interest for legislators to accept campaign contributions from the very groups about whom they will be making decisions needs to be acknowledged and addressed (*see sidebar*). In a turf battle between two professions, differences in political and financial strength

often allows one profession to “out-gun” the other with factors unrelated to competence and empirical evidence. Practice authority decisions made in this environment do not necessarily answer the question of which professionals are qualified to provide safe, competent and accessible health care.

Regardless of these external factors, appropriate and complete evidence is not always available or easy to find, and relevant standards may change over time. For example, the rationale relied upon by the early advocates for all-inclusive medical acts for physicians at the turn of the century may not be viewed as favorably by today’s experts in empirical evidence. Nonetheless, no state practice act today prohibits any licensed physician from performing surgery even though surgical competence may vary tremendously depending on training and specialty. Furthermore, the range of possible sources of evidence is large and the data collection techniques and methodologies differ. Research is expensive, time-consuming and constantly evolving. This can be perceived by those seeking change as a relentless “raising-of-the-bar.” The “gold standards” of one profession’s research philosophy may run counter to another profession’s. Consideration of non-Western therapies and disciplines may be particularly challenging when evidence may come from other countries or in other languages.

Complicating the matter of evidence and competence is the issue of burden of proof. Consensus is far from reached on whom the burden should fall. Many would argue that the profession seeking new or changed practice authority should bear the burden of demonstrating to the decision-makers that its members are competent to provide the care in question. However, from hearing records, written testimony and



lobbying efforts, it appears that other organized professions that might also be affected by the proposed changes often assume the duty of “proving” that the petitioning profession is not competent to provide the services in question. It is unclear whether this shifted burden was the intent of legislators and whether it serves the best interests of the public.

Keeping these issues in mind and intending to offer guidance to legislators facing the challenges of reforming the process for determining professional practice authority, the Pew Commission offers the following recommendations for states to consider today and to work to implement over the coming years.

#### RECOMMENDATIONS FOR PROFESSIONAL PRACTICE AUTHORITY

**Recommendation 7** The national policy advisory body recommended above should develop standards, including model legislative language, for uniform practice authority acts for the health professions. These standards and models would be based on a wide range of evidence regarding the competence of the professions to provide safe and effective health care.

A national policy advisory body (*see recommendation one, page 11*), composed of members not captured by the interests of state regulatory agencies or state health professions associations, would be able to develop evidence-based models and standards for professional practice authority in a non-political forum.

While this policy body needs to be established at the national level, and possibly within the Federal government, the Pew Commission emphasizes that it does not make this recommendation lightly or with the intent of creating new and unnecessary bureaucracy. The goal is to address the shortcomings of the decision-making process regarding practice authority and to limit the negative aspects of turf battles. The intended outcomes would be evidence-based practice authority acts that are uniform across the states.

Examples of evidence that have been or could be relied upon by nurse practitioners seeking changes in practice authority through state legislation.

States' laws and experiences regulating nurse practitioners

- Legislative and regulatory tracking by professional associations and services such as Health Policy Tracking Service at the National Conference of State Legislatures
- Questionnaires sent to the states

Research about nurse practitioners, their practices, and outcomes of services provided

- Meta-analyses (e.g. Brown and Grimes, 1992; Office of Technology Assessment, 1986)
- Survey articles (e.g. Munding, 1994)
- Office of the Inspector General reports (1993)
- Agency for Health Care Policy and Research bibliography (Weston, 1990)
- Individual studies (contained in meta-analyses) addressing cost, access, quality
- Pilot and demonstration project descriptions and outcomes (e.g. Freudenheim, 1997)

Individual state studies of practice

- For example: Prescribing of Controlled Substances by Advanced Registered Nurse Practitioners, A Report to the Governor of Florida and the Florida Legislature, 1997

*(continued)*

In carrying out its mandate, the national policy advisory body would start by establishing guidelines that define, for example, the types of evidence permissible for consideration (*see sidebar*). By setting up guidelines in advance that are based on consensus and advice of experts, some of today's problems might be avoided. For example, it is not unusual for one profession to testify that the research techniques, methodologies or data analyses relied upon by a profession seeking changes in their practice act are substandard. It is difficult for state legislators to know the validity of such statements when the criticizing profession has an interest in the outcome.

The range of potential sources of evidence is broad. The national policy advisory body might consider educational standards, outcomes data and expert testimony. It would also consult with the states to identify existing models and practice acts and consider using the least restrictive practice acts for each profession

as models for the rest of the states, unless there is any indication that a given act was enacted on grounds other than evidence of competence of a profession. In addition, it would look to model practice acts developed by the professions, controlled clinical trials, customary usage, surveys, natural experiments, data from demonstration projects, and meta-analyses. It would decide which of these sources and

methodologies were acceptable, and if necessary, weight them.

Once the guidelines were in place, this national-level body would review the evidence available. It would then develop and disseminate models (examples to emulate) and standards (for comparison and measurement) to the states, which would choose to implement them. The models and standards would be updated regularly as appropriate to acknowledge new evidence about the evolution of health care practice. Throughout its

work, the advisory body would assume that professions would share practice authority when appropriate and justified by the evidence at hand.

*(continued from previous page)*

Educational curricula, training and accreditation standards

Data collection from state and federal agencies

- U.S. Drug Enforcement Agency rules and regulations regarding prescriptive authority for controlled substances (Code of Federal Regulations, Title 21, 1998).
- State regulatory boards and national databanks regarding malpractice payments and disciplinary actions

Opinion pieces—from the professions, health care leaders, foundations, health policy advocates, elected officials

#### **Recommendation 8**

States should enact and implement scopes of practice that are nationally uniform for each profession and based on the standards and models developed by the national policy advisory body.

The Pew Commission recommends that the individual states maintain responsibility for enacting and implementing practice authority legislation for the health professions as necessary. Unlike today's system however, the states should adopt the models and standards developed by the national policy-making body so that the practice acts are uniform among the states, more grounded in evidence and demonstrations of competence and less influenced by the current shortcomings of state-based "turf battles."

Although a national policy advisory body is better suited to develop evidence-based standards and models for professional practice authority, the states are well positioned to

implement those standards and models. The individual states have the flexibility to create boards as required, to site the regulated professions under appropriate boards, and to delegate licensing and disciplining authorities to the regulatory boards. The focus of the national policy advisory body in this arena would be limited to establishing the range of services and categories of care the professions should be allowed to provide.



#### Recommendation 9

Until national models for practice authority acts can be developed and adopted, states should explore and develop mechanisms for existing professions to evolve their existing practice authority and for new professions (or previously unregulated professions) to emerge. In developing such mechanisms, states should be proactive and systematic about collecting data on health care practice. These mechanisms should include:

- Alternative dispute resolution processes to resolve scope of practice disputes between two or more professions;
- Procedures for demonstration projects to be safely conducted and data collected on the effectiveness, quality of care, and costs associated with a profession expanding its existing scope of practice; and
- Comprehensive “sunrise” and “sunset” processes that ensure consumer protection while addressing the challenges of expanding existing professions’ practice authority and regulating currently unregulated healing disciplines.

❖ *See legislative implementation template in Appendix A.*

The establishment of a functioning national policy advisory body responsible for collecting, researching and disseminating models and standards of practice authority acts will take time. The Pew Commission proposes that the states proactively lay the foundations for the national policy advisory body in the interim. Specifically, states should find reasonable and safe ways for the health professions and disciplines to evolve their practice authority. The first step in the process would be for the states to employ mechanisms for the collection of data on health care practice.

Underlying this activity should be the following themes: health care professions and disciplines should be able to evolve and expand their practice domains to incorporate safe and effective practices; a number of professions and disciplines that use non-mainstream therapies safely and effectively should be recognized and regulated as appropriate; and any change in practice authority should be done with the interests of the patients, clients and consumers foremost in the mind of the decision-makers.

Three possible mechanisms for states to employ as they expand the collection and analysis of evidence regarding health care practice are described below in general and in the legislative implementation appendix in more detail.

Alternative dispute resolution processes

Alternative dispute resolution (ADR) mechanisms have been tested in a number of arenas as methods to settle conflicts where the formalities, costs or adversarial framework of the legal system is not appropriate. Following Hawaii's lead, states should explore the use of ADR to resolve conflicts between the health professions over practice authority (*see sidebar*). State legislators familiar with the current battles between optometrists and ophthalmologists concerning laser surgical procedures and conflicts

### Alternative Dispute Resolution as a Mechanism for Resolving a Scope of Practice Dispute

For more than three years, the Hawai'i state legislature considered numerous bills and passionate (yet often conflicting) testimony in a scope of practice authority battle between psychologists and psychiatrists over prescriptive privileges. Psychologists sought authorization to prescribe drugs to their patients, arguing that this authority would improve access to mental health care in rural under-served communities. Psychiatrists argued that psychologists did not have the proper training to prescribe safely and that there were less costly and more efficient ways to meet the needs of this population.

In 1990, the legislature used a unique process to resolve the battle. The legislature turned to Alternative Dispute Resolution (ADR) which uses a neutral third party to facilitate resolving the dispute. The legislature called upon The Hawai'i State Judiciary Center for ADR and charged it with facilitating this dispute by compiling a "single text" document which contained all of the arguments, data, citations and sources from testimony offered by both sides.

During a six-month period, The Center for ADR convened three roundtable sessions that were open to anyone who wished to testify. Between 25 and 30 people attended each roundtable, and although there were many representatives of professional associations, consumers and individual professionals also participated. Center facilitators successfully carried out their charge and returned a single text document to the legislature. The legislature determined that the psychologists had not adequately proved their competence to prescribe and the proposed bill did not pass (Chandler, 1997; Kent, 1997, 1998; American Psychiatric Association, 1996).

over prescriptive privileges for psychologists would rely on the “fact-finding” model of ADR to assist them in making the decisions required in the public’s interest.

With a fact-finding charge from legislators, a body of interested parties facilitated by an ADR expert would be convened to collect and review all the evidence presented on the question at hand. This group would then come to consensus on the quantity, quality and relevance of the available evidence and submit their findings to the legislature. The legislators would then rely on that document to make their decision regarding the request to establish or change a practice authority act. See the template in Appendix A for more information and guidance for writing relevant legislation.

Guidelines and parameters for demonstration projects – As health professions and disciplines evolve to meet the needs of their patients and clients and to incorporate new knowledge and technologies into their practices, they may face significant hurdles. One of these challenges is in designing and conducting research that will accurately reflect their competence to provide services that have not traditionally been within their practice authority.

While innovation and evolution within the health professions is a necessity, legislatures must safeguard against potentially unreasonably inappropriate, unsafe and ineffective care. Balancing the need for valid data on changed practice authority with the need to protect the public, legislatures should develop the guidelines and parameters necessary to conduct safe and informative demonstration projects for professions seeking changes in their practice authority acts. Without such guidelines, it is difficult, if not impossible, to conduct research safely that compares outcomes of practitioner care.

These demonstration projects would allow practitioners to *safely* provide care that lies beyond their current statutory authority with the goal of collecting data on the quality and costs of care so delivered. Legislative guidance should be available to groups of professionals and health care delivery organizations so that they may design and implement pilot programs for controlled innovation and experimentation of more flexible use of health care providers. See the template in Appendix A for more information and guidance for writing relevant legislation.

Comprehensive “sunrise” and “sunset” processes – In some states, legislators can rely on standard “sunrise” processes when reviewing requests for new or changed practice authority acts. These processes, when comprehensive, include criteria for review, allowances for public participation and recommendations for evidence-based decision making. The Pew Commission recommends that all states employ such processes that facilitate the work of legislators and professionals while ensuring that the public is protected.

Similarly, some states have enacted “sunset” laws to use for periodic review of existing professions and their regulatory structures. The value of such laws, when written and implemented correctly, is significant in their effect to hold self-regulatory entities accountable to the public. Optimally, these laws would provide a mechanism for evaluation to assure that regulatory bodies are operating effectively and efficiently and that professional practice acts are kept current and relevant. See the template in Appendix A for more information and guidance for writing relevant legislation.

## V Continuing Competence

*The state regulatory role in ensuring the continued competence of health care practitioners*

### CURRENT ISSUES

Of the ten issue areas identified in the 1995 report *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, the call for requiring continuing competence assessments of health care professionals has likely generated the most action in accord with the recommendation (*see sidebar*). In the formal responses to the 1995

#### Recent activities regarding continuing competency

- The Interprofessional Workgroup on Health Professions Regulation held a two-day “Continued Competency Summit” in July 1997. Attended by representatives of many different health professions, the conference focused on methods of assessment and other issues related to continued competency (Interprofessional Workgroup, 1997).
- Citizen Advocacy Center, a training, research and support network for public members of health care regulatory and governing boards, held a two-day conference in December 1996 entitled, “Continuing Professional Competence: Can We Assure It?” (Citizen Advocacy Center, 1997).
- The National Council of State Boards of Nursing has developed Personal Accountability Profiles to serve as a framework for licensed nurses to document learning needs, learning plans and goals/objectives and strategies for development and evaluation as to whether goals/objectives have been achieved (Sheets, 1997).
- The State of Washington’s Department of Health has established an interdisciplinary task force to

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report, this recommendation received the highest score for level of concern and one of the highest scores for level of support (Gragnola and Stone, 1997). The high level of activity may be due to tremendous tension between consumer anxiety over quality of care and practitioner anxiety over being asked to demonstrate their competence more than once.

While continuing education and life-long learning have numerous benefits, the Pew Commission agrees with the assessment that continuing education credits do not guarantee competence (Relman, 1997). Continuing education simply is not sufficient to ensure quality throughout a practitioner’s career. Additionally, few if any regulatory boards require their licensees to *demonstrate* their competence at any point after initial licensure and current systems for detecting incompetence are imperfect. Perhaps most pressing is the fact that the monumental shift



to new reimbursement and delivery structures in this country has highlighted the need to pay attention to quality of care. Underlying managed care's critics and legislative restraints is the concern that high quality health care—and a professional's competence to provide it—may suffer from too much attention on reducing costs. Requiring demonstrations of competence during professionals' careers could shift attention to the quality of care delivered to patients and clients.

Regulators could be involved in competence requirements at the four junctures identified by the National Council of State Boards of Nursing: entry to practice, for continued authority to practice, reentry to practice, and after disciplinary action (Citizen Advocacy Center, 1997). To date, however, legislatures have largely declined to require that regulatory boards insist that their licensees demonstrate competence for continued authority to practice.

Historically, the challenge has been in defining and measuring competence in ways that meet the needs of consumers for safe and effective care without unreasonably burdening the individual practitioner. For more than a century, policy makers and consumers have used a complex assortment of methods to indirectly evaluate competence and quality. Both preventive measures and punitive interventions serve as proxies for demonstrations of competence.

Consumers rely largely on “positive” or preventive mechanisms such as education at accredited institutions, licensing examinations, character checks, and continuing education requirements to protect them from incompetent practitioners. The system is then bolstered with “negative” or punitive interventions to deal with problems after they have arisen. These interventions include regulatory departments for complaints,

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look at continuing competency efforts, and to examine the feasibility of continuing competency requirements for health care professionals (Ehri, 1998).

- The Colorado Personalized Education for Physicians is a model program for individualized competency assessment along with a personalized learning plan. It is used by physicians from around the country on a self-referral basis; referrals can also be made by employers or the Board of Medical Examiners (Colorado Personalized Education for Physicians, 1998).
- California's SB 1981, if enacted, will require persons licensed to practice podiatric medicine to demonstrate their competence throughout their careers at regular intervals via a number of different options (1998).

enforcement and discipline, as well as extra-regulatory bodies – peer review bodies, criminal justice, malpractice and tort actions – that serve as post-occurrence safety nets to further protect the public and provide avenues of redress.

Despite all these efforts, significant numbers of patients, clients and consumers continue to suffer the consequences of health professional incompetence (Leape, 1994). A RAND Corporation study for the National Coalition on Health Care found that, “there are large gaps between the care that people should receive and the care they do receive.” This is true for preventive, acute and chronic care (Schuster et. al., 1997). While Public Citizen’s Health Research Group reports that 16,638 doctors were disciplined (primarily for: criminal convictions; substandard care, incompetence or negligence; mis-prescribing or over-prescribing drugs; substance abuse; and professional misconduct) by either state medical boards or federal agencies as of January 1997, the group also estimates that this makes up only a small percentage of the total number of incompetent physicians (Wolfe, 1998).

Partly in response to these indicators of low quality care, external factors – ranging from the evolution of public expectations and demands for accountability to market-driven rationalization of health care costs – have already changed the way competence is assessed and enforced. Currently, competence is often better determined by private sector assessments and employer evaluations than by the self-regulating boards. Efforts by the National Committee for Quality Assurance to privately regulate health plans are beginning to include attention to the individual practitioner. Total quality management or continuous quality improvement endeavors that include individual practitioners as well as systems of care may be shifting the level of quality of health care upward. Some of the medical specialty boards and other private sector professional boards, also have developed continuing competence requirements.

The potential for collaboration between public regulators and private sector credentialing bodies is significant but the professions are not in agreement on the prospect. Representatives from medicine have voiced their preference that public regulators and private certifying agencies keep their distance, whereas a collaborative

relationship between regulation and private specialty credentialing is developing in nursing. This split in perspective may be due in part to different histories of the professions; the medical license is all-inclusive and state boards of medicine have not traditionally recognized specialties. Nursing regulation, on the other hand, recognizes professional specialization (Citizen Advocacy Center, 1997).

Whether done by the private or the public sector, or by a partnership of the two, the challenges of better assessing and assuring continuing competence are significant but not insurmountable. They include coordinating efforts between establishing competence at the entry-to-practice level with ongoing assessment throughout a practitioner's career; identifying and researching the links among practitioner competence (at initial licensure and re-licensure), high quality care, and consumer expectations for accountability; and knowing when concerns over quality and competence must include looking at the broader systems of care in which individual professionals practice. In addition, regulators must address the question of how often practitioners must demonstrate their competence. These periods between demonstrations will likely vary from profession to profession and depend on the practice circumstances of individual practitioners.

Requirements that practitioners demonstrate competence throughout their careers must also be supported by meaningful ways of ensuring that practitioners meet those requirements. When requirements are not met, enforcement mechanisms might include sanctions, restriction of privileges, revocation of license or public or private censure. Positive incentives for meeting requirements might include licensing fee reductions and public acknowledgments.

Given the current social, political and economic environment, the regulatory system may have a small window of opportunity to commit itself to answering these questions and assuming the responsibility for requiring continuing competence of its licensees. Although the professions, private sector testing and practice institutions may all be involved, the role of the state is critical. One entity must be capable of, and responsible for, collecting and coordinating the information from the various sectors, including tying continuing competency requirements to the disciplinary process.

## RECOMMENDATION FOR CONTINUING COMPETENCE

- ❖ **Recommendation 10** States should require that their regulated health care practitioners demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their careers.

❖ *See legislative implementation template in Appendix A.*

In addition to being responsible for setting competence standards for individuals wishing to enter professional practice, state regulatory boards should expand their responsibilities to include requiring regulated health care practitioners to demonstrate their competence throughout their careers. Legislators also should encourage unregulated health professions and disciplines to establish standards regarding continuing competence.

The current system that relies on continuing education and disciplinary action is insufficient. And, although the private sector has begun to ensure practitioner competence, it is unlikely that it alone can or will be accountable ultimately for developing and sustaining an effective system. State legislators and regulators can provide the necessary support, incentives and accountability lacking in the private sector. Moreover, the states, as protectors of the public's health, safety and welfare, can no longer ignore the implications of *not* addressing the issue of health professions competence beyond initial licensure.

With the goal of working in conjunction with the private sector, states would take the lead in defining competence to include basic knowledge, skills and judgment and also specialized knowledge, skills and judgment. Definitions should eventually include less clinical competencies such as communication skills, ethics, concepts of continuous quality improvement, the capacity to admit errors and the ability to empathize.

States should also develop criteria by which private sector competence assessments would be deemed to have satisfied state requirements. For example, states might develop mechanisms by which regulatory bodies can accept voluntary certification by private sector entities as evidence of public sector requirements for demonstrating continuing competence.

With the establishment of the national policy advisory body (*see recommendation one, page 11*), definitions, models and standards for continuing competence assessment would be researched, developed and disseminated by that body to the states to implement. States and private sector entities would in turn provide the national policy advisory body with their findings on the effectiveness and benefits of the models they have employed. Of particular importance will be the need to relate continuing competence assessments to practice performance and scope of duties or services provided. This may lead to re-evaluations of practice acts that are particularly broad, if it becomes evident that continuing competence should be linked to areas of specialty or expertise.

Ultimately, national standards for continuing competence assessments would complement the national standards for practice authority acts. Differences from state to state in requirements for continued licensure within any given profession cannot be justified any more than differences in scope of practice acts. One relevant model that might be considered is the Federal Aviation Administration (*see sidebar*), which requires the same periodic demonstrations of

### The Federal Aviation Administration: A Nationally Unified Regulatory System

The Federal Aviation Administration (FAA) is an example of a nationally unified system of professional, facility and equipment regulation. The Air Commerce Act of 1926 charged the Secretary of Commerce with fostering air commerce, issuing and enforcing air traffic rules, licensing pilots, certifying aircraft, establishing airways, and operating and maintaining aids to air navigation (Federal Aviation Administration, 1998).

For all pilots, initial licensure for competence, continuing competency requirements, testing and discipline are administered by one federal agency. Through the Federal Aviation Requirements, all pilots at all levels are qualified for flying based on physical condition (medical certificate), aeronautical experience (logbook), knowledge (written tests) and skill (flight tests).

The pilot certification and re-certification process becomes more rigorous as a pilot's responsibility increases (e.g. larger aircraft, larger passenger loads, flying using instruments/technology, night flying, and permission to captain an aircraft). The two examples below illustrate the process:

- Student Pilot License is restricted to flying without any passengers, within twenty-five miles of the home airport, and in good flying conditions. The FAA requirements are for a third-class medical certificate (lowest grade), 40 hours of flight time (half of which with a certified instructor), no written test and a single flight test administered one time.
- Air Transport Pilot is necessary for any pilot flying a turbojet with more than ten-seat capacity.

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Requirements include passing the first class medical certification (highest level), having 1500 hours of flight time (broken into a variety of categories including night flying, instrument time, pilot-in-command time, etc.), and having completed testing for Instrument Certification. An Air Transport Pilot must re-test as often as every six months, depending on job requirements, at both flight and medical levels (Code of Federal Regulations, Title 14, 1997).

competency from specified categories of licensed pilots (Leape, 1994).

Alternative models for determining whether practitioners are competent throughout their careers need to be tested and evaluated for effectiveness, costs and benefits. Currently, a number of different tools are being used to measure education and knowledge, experience and demonstrated ability (*see sidebar*). These

measurements include standardized examinations, computer simulations, standardized patients, objective structured clinical examinations, office record reviews, practice evaluations and peer review. Patient satisfaction may also serve as an adjunct to

assessment tools by confirming observations. All of these tools need to be evaluated for validity, reliability and fairness (Citizen Advocacy Center, 1997).

The actual assessment of competence may best be left to the professional associations, private testing companies and specialty boards that would continue their current efforts to develop and offer continuing competence assessment tools that are meaningful (empirically-based, valid and reliable), effective (psychometrically sound) and cost-efficient.

To encourage market strengths while protecting consumers from market failures, parameters should be set around this

#### College of Nurses of Ontario Quality Assurance Program

Among other things, Ontario, Canada's Regulated Health Professions Act requires that the professional colleges (akin to the professional boards in the United States) develop and maintain programs and standards to promote the continuing competence of members. In accord with this requirement, the College of Nurses of Ontario (CNO) has taken a comprehensive approach to ensuring continuing competence throughout practicing nurses' careers. The College's Quality Assurance Program has three parts, all of which can be tailored to meet the needs of individual practitioners:

- Reflective practice;
- Competence assessment; and
- Practice setting consultation.

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potentially lucrative business. The states should establish the assessment standards they expect their licensees to meet, thereby stimulating private sector responsiveness and minimizing the chance of inappropriate, irrelevant or unreasonable standards being set. States might begin this process by cataloging and analyzing continuing competence requirements of private accreditors.

Finally, there will always be health care professionals whose competence, for a number of reasons, might not be assessed by private sector institutions. To address the limitations of the private sector, states would also be responsible for focusing on the practitioners who “fall through the cracks” or are outliers. State governments would have to address this reality and be responsible, for example, for establishing relevant triggers that would link private quality assurance mechanisms with state boards to identify outliers. See the template in Appendix A for more information and guidance for writing relevant legislation.

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As of 1998, only the first part—reflective practice—has been implemented as a requirement of practicing nurses. The practice setting component will be implemented in 1999 and the competence assessment component is in development.

Nurses in the province must complete five steps and submit relevant documentation to satisfy the reflective practice component: complete a self-assessment; get feedback on his or her practice; create a learning plan; learn (i.e. do the activities identified in the individual's learning plan); and evaluate the learning. Although all nurses must complete all five steps, they may choose from among several options for actually meeting the requirements. These options include using a professional development system at their workplace; using their own or a CNO-produced self-assessment tool; or using formal education programs.

Future requirements will include the competence assessment and practice setting consultation components of the Quality Assurance Program. When in place, these will require that nurses: 1) complete a self-directed competence assessment tool, an interview with an assessor and/or observation of practice by an assessor; and 2) participate in the Practice Setting Consultation Program, which is designed to encourage nurses and other members of multidisciplinary teams to work with their employer to ensure that the key attributes of a quality practice environment are in place. These attributes include care delivery processes, communication systems, facilities and equipment, professional development systems, leadership, organizational supports and response systems (College of Nurses of Ontario, 1998).



## Legislative Implementation Templates

This appendix contains templates for model legislation that will assist legislators and legislative staff who wish to draft and enact legislation based on specific recommendations in this report. These templates provide statements of legislative purpose and identify the most significant elements necessary to implement each of the recommendation subject areas. Under each issue is a detailed discussion of the policy options which states should consider in drafting legislation. While there are differences between states, these templates are intended to be generic enough for use by state legislators as a guide to craft legislation and as a framework for regulatory reform of the health professions.

### Recommendation 2

States should require policy oversight and coordination for professional regulation at the state level. This could be accomplished by the creation of an oversight board composed of a majority of public members or it could become the expanded responsibility of an existing agency with oversight authority. This policy coordinating body should be responsible for general oversight of that state's health licensing boards and for assuring the integration of professional regulation with other state consumer regulatory efforts (e.g. health facility and health plan regulation).

*See report text for a full discussion of this recommendation*

**Purpose of legislation:** In order to coordinate state health policy and health professions regulation, and provide general oversight of regulatory bodies, states will need to either create a new oversight board or empower an existing state agency to oversee the individual professional licensing authorities.

### ISSUE 1: Functions and Authority of the Oversight Entity

The following seven identified functions define the powers, duties, and final authority of this new oversight board or empowered existing agency. These functions shall be assigned to either a new oversight board or an existing agency with oversight authority, depending



on the route chosen by a particular state. The conditions under which the designated oversight entity would exercise any or all of the functions are if:

1. An issue involves more than one profession and therefore transcends the jurisdiction of any individual licensing board; and/or
2. An issue is one that calls for a uniform state policy in order to best protect consumer health, welfare, or safety.

Function 1: Establishing, measuring, and evaluating performance objectives for individual boards (*see sunset review implementation template below*):

- A. Develop and adopt consistent performance measures for licensing boards.
- B. Evaluate licensing boards by means of internal audits or independent audits that are based on performance measures.
- C. Establish standard procedures for responding to consumer complaints and for conducting disciplinary investigation and adjudication proceedings.

Function 2: Ensuring consistency and uniformity of processes and outcomes:

- A. Develop consistent agency processes and timeframes for each licensing board.
- B. Establish requirements for demonstrating continuing competence, and when available from the national policy advisory body, implement national models and standards.
- C. Ensure consistency in enforcement activities of licensing boards.

Function 3: Ensuring coordination among individual licensing boards:

- A. Make decisions on collaborative practice and scope of practice dispute issues (*see scope of practice implementation template below*).
- B. Develop data sharing policies and mechanisms for their use.
- C. Coordinate joint enforcement actions between two or more licensing boards.

Function 4: Ensuring coordination between licensing boards and other state or federal agencies:

- A. Develop data sharing policies and mechanisms for their implementation and use.
- B. Coordinate enforcement actions with facility regulators and other regulatory systems or agencies.
- C. Make recommendations to other regulatory agencies (e. g. Department of Health, Insurance Department, or criminal justice agencies) to encourage coordinated regulation.

Function 5: Establishing criteria for the appointment of individual licensing board members and implementing effective education and training programs:

- A. Develop and adopt criteria for board member selection and appointment to licensing boards.
- B. Develop and conduct board member training programs.
- C. Develop and conduct staff training programs.
- D. Develop rosters of experts in each specialty and sub-specialty area to ensure the availability of expert opinion, as needed.

Function 6: Establishing programs and criteria for releasing practice-relevant information to the public:

- A. Develop and adopt guidelines for release of information about health care practitioners.
- B. Develop and implement public information, education and outreach programs.
- C. Develop ombudsman programs to assist the public in gaining access to individual licensing boards.

Function 7: Establishing incentives for effective enforcement:

- A. Propose and adopt rules to implement functions one through six.
- B. Review and approve final budget requests of each licensing board.
- C. Develop criteria for establishing the privatization of certain functions of each licensing board's activities.

- D. Complete an annual report to the Governor each year outlining the activities and accomplishments of the oversight authority.

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#### ISSUE 2: Relationship of Oversight Entity to Other Boards

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This legislation envisions that existing individual licensing boards will continue to perform two basic functions:

1. The granting of licenses to qualified individuals; and
2. The administration of investigation and discipline on a case-by-case basis.

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#### ISSUE 3: Powers, Resources and Staffing

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The oversight entity, whether a new board or an existing agency, must have certain resources in order to effectively carry out the seven functions. These resources include:

1. Rulemaking authority to enforce any guidelines established by the new board or existing agency.
2. Approve all proposed rules adopted by the individual licensing boards.
3. Authority to contract with outside private entities for specific functions.
4. Access to all confidential materials collected or maintained by the licensing boards that the oversight agency oversees.
5. Adequate staffing and financing.

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#### ISSUE 4: Conflicts of Interest

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Special attention should be paid to avoid conflict of interest in the staffing and the appointment of legal counsel to the oversight entity. These two specific areas of attention are:

1. If all licensing boards are represented by the Attorney General, the oversight entity – whether a new board or an existing agency – should have outside independent counsel concerning oversight issues.
2. Employees staffing the oversight agency should not also be employed by one of the licensing boards being overseen by the agency.

## ISSUE 5: Oversight Board Structure and Membership

For states that choose to create a new oversight board, rather than assign the functions to an existing agency, a number of options have been provided for both membership composition and selection. A discussion of each of the options is provided in diagram form. Table I provides three membership models for consideration with a brief outline of the pros and cons of each. Table II provides some of the issues and options to be considered in selecting and appointing board membership. Consideration should also be given to the following:

1. The oversight board should have between nine and fifteen members. This is a large enough size to be representative of interested parties but not so large as to become bureaucratically and politically unwieldy.
2. The total membership should be an odd number of members to assure voting majorities.

Model	Membership	Pros to consider	Cons to consider
1	<ul style="list-style-type: none"> <li>• All consumers</li> </ul>	<ul style="list-style-type: none"> <li>• Increased credibility with the public and legislature</li> <li>• Increased accountability and responsiveness to the public</li> <li>• Reduce professional bias in scope of practice and other policy decisions</li> <li>• Less likely to be wedded to status quo</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of expertise to make policy decisions based on technical underpinnings</li> <li>• May be elitist unless other than token member reimbursement</li> <li>• Not acceptable to the professions</li> <li>• Less political clout than other models</li> </ul>
2	<ul style="list-style-type: none"> <li>• 51% consumer</li> <li>• 49% agency and/or board staff and non-professional interest groups (e.g. HMOs, hospitals, and nursing homes); No licensed professionals or their associations</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce professional bias in scope of practice decisions</li> <li>• Hands-on understanding of real world problems associated with current licensing system</li> <li>• Enough political clout to ward off pressures to keep status quo</li> </ul>	<ul style="list-style-type: none"> <li>• Not acceptable to the professions</li> <li>• Some concern about sufficient expertise</li> <li>• Perception that concerns for quality of care may be weaker than in other models</li> </ul>
3	<ul style="list-style-type: none"> <li>• 51% consumer</li> <li>• 49% agency and/or board staff, non-professional interest groups, and licensed professionals and their associations</li> </ul>	<ul style="list-style-type: none"> <li>• Most acceptable to professional groups</li> <li>• Brings most profession-specific expertise to the table</li> <li>• Most consistent with the boards they are regulating</li> </ul>	<ul style="list-style-type: none"> <li>• Wedded to the status quo</li> <li>• Least credible</li> <li>• Least accountable</li> <li>• Most potential for professional bias in scope of practice decisions</li> </ul>

Further, if a new oversight board is established consistent with one of the above models, it must be noted that potential board members may have more than one affiliation. For example, the executive director of an agency may be a licensed professional (licensed by the agency he or she directs or by another agency). A licensed physician may be a director of a health maintenance organization (HMO), and so be appointed to represent the HMO rather than serve in the capacity of a licensee. Each state must decide if this type of overlap is appropriate based on the representation model they choose. Other board membership issues are discussed in the Table II below.

Potential Membership Pool	Options To Consider Regarding Selection Criteria	Options To Consider Regarding Appointment Process
Consumers	Include: <ul style="list-style-type: none"> <li>• Demonstrated public service</li> <li>• Interest in health care issues</li> </ul> Exclude: <ul style="list-style-type: none"> <li>• Conflict of interest based on family or pecuniary relationships</li> </ul>	<ul style="list-style-type: none"> <li>• Governor</li> <li>• Legislature</li> <li>• Elected by consortium of consumer groups</li> </ul>
Staff of boards or agencies (Including board executive directors and departmental senior officials)	Include: <ul style="list-style-type: none"> <li>• Must be currently employed in position</li> </ul> Exclude: <ul style="list-style-type: none"> <li>• Individuals also holding active health care professional license</li> </ul>	<ul style="list-style-type: none"> <li>• Governor</li> <li>• Legislature</li> <li>• Elected by licensing board chairs</li> </ul>
Other interest groups (Including private sector health care provider institutions, associations, etc.)	• No criteria Exclude: <ul style="list-style-type: none"> <li>• Individuals who hold active health care professional license</li> </ul>	<ul style="list-style-type: none"> <li>• Governor</li> <li>• Legislature</li> </ul>
Licensed health care professionals	• Any professional Exclude: <ul style="list-style-type: none"> <li>• Current professional board members</li> <li>• Past professional board members</li> <li>• Members with disciplinary histories</li> <li>• Inactive licensees</li> </ul> Require: <ul style="list-style-type: none"> <li>• Current professional board members</li> <li>• Past board members</li> <li>• Mix of all</li> <li>• Active licensees</li> <li>• Inactive licensees</li> </ul>	<ul style="list-style-type: none"> <li>• Governor</li> <li>• Legislature</li> <li>• Appointed by professional association</li> <li>• Elected by profession (e.g. all licensed members of profession(s) in question vote to elect representative to oversight board)</li> </ul>

## ISSUE 6: Oversight Board Chairperson

There are two options to consider in selecting a public, non-professional chairperson:

1. By Governor's appointment. If a chairperson is appointed, he or she is more likely to have good rapport with Governor (especially regarding budget issues and controversial scope of practice decisions); or
2. Elected by the oversight board members. This may be better for the overall working dynamic of the board.

**Recommendation 9** Until national models for scopes of practice can be developed and adopted, states should explore and develop mechanisms for existing professions to clearly define and expand their existing scopes of practice and to allow for new professions (or previously unregulated professions) to emerge. In developing such mechanisms, states should be proactive and systematic about collecting data on health care practice. These mechanisms should include:

- Alternative dispute resolution processes to resolve scope of practice disputes between two or more professions;
- Procedures for demonstration projects to be safely conducted and data collected on the effectiveness, quality of care, and costs associated with a profession expanding its existing scope of practice; and
- Comprehensive “sunrise” and “sunset” processes that ensure consumer protection while addressing the challenges of expanding existing professions’ practice authority and regulating currently unregulated healing disciplines.

*See report text for a full discussion of this recommendation*

## Alternative Dispute Resolution

Purpose of legislation: To enact guidelines for the development and use of alternative dispute resolution (ADR) processes by legislators as one method of resolving disputes between two or more health professions over practice authority acts.

#### ISSUE 1: Establishment and Administration of ADR Function

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Establish who will perform the ADR function (the following assumes the use of the “fact-finding” ADR model – the use of a neutral third-party to collect relevant facts and produce a final recommendation):

1. Determine whether there is a current ADR entity (public) in existence in the state that can perform this ADR function.
2. If no ADR entity exists, consider whether to establish and fund a public ADR entity or whether to contract with a private entity.

#### ISSUE 2: Applicability to Scope of Practice Disputes

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Establish applicability of ADR to scope of practice disputes:

1. Establish forms and filing procedures for parties to jointly request ADR (ADR process only available if all parties agree to participate).
2. Establish what information must be included on the form so that the ADR entity can determine that the dispute is appropriate for resolution (e.g. inability of parties to resolve their differences voluntarily; anticipated prolonged legislative debate; resolution of dispute is in public’s best interest and no harm to public’s health foreseen).
3. Determine parties’ obligations and duties when disputes are accepted for resolution (e.g. parties must provide requested information; parties agree to follow the ADR entity’s recommendation).

#### ISSUE 3: Procedures Used in the ADR Process

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Establish procedures for beginning and conducting the ADR process:

1. Require ADR entity to hold an adequate number of hearings, to take testimony of witnesses, and to provide an opportunity for public input.
2. Establish public notice requirements (e.g. local newspaper, other media).
3. Establish reasonable timeframes for fact finding, reviewing and analyzing facts, and developing and finalizing recommendation.
4. Establish format and process for final reports (and documents) and their submission.

#### ISSUE 4: Implementation of ADR Recommendation

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Provide for the implementation of the ADR recommendation:

1. Identify the entity that will receive the recommendation (options include: executive branch agency, legislative committee, appropriate oversight board or individual boards).
2. If implementing legislation is required, identify the entity responsible for introducing the draft legislation (which may be same entity that received the recommendation).
3. Provide that the draft legislation accurately reflects the ADR recommendation.
4. Determine whether to limit the “new” testimony that would be allowed at hearings on the draft legislation (e.g. allow the introduction of only relevant information not available during ADR process).

#### ISSUE 5: Allocation of Costs

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Provide for the allocation of costs for ADR. The options include:

1. State bears costs through the general fund.
2. Parties share costs.
3. State and parties share costs.
4. Portion of license fees are devoted to reasonable ADR costs.

### Demonstration Projects for Scope of Practice Innovation

Purpose of legislation: To authorize demonstration projects that provide an empirical basis for rational development of legally defined scope of practice provisions, which reflect evolving clinical competence, and make optimum use of skilled health care practitioners. Scope of practice (practice authority) demonstration projects are intended to facilitate the optimal safe utilization of the clinical competence of health care practitioners.

#### ISSUE 1: Approval Authority

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Establish what entity should review, determine the validity, and approve the proposed demonstration project applications. This entity should not be any one licensing board, given



that these issues are inherently interdisciplinary, but should be an oversight board, if established, or a centralized agency function.

#### ISSUE 2: Duties and Powers of Approval Authority

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Establish that the oversight board or centralized agency may:

1. Approve, deny, modify or combine applications for a demonstration project; and
2. Solicit public comment on proposed demonstration projects.

#### ISSUE 3: Application Contents

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Establish that the following should be included in the application for a proposed demonstration project:

1. A description of the benefit to the public that will result from the proposed change in practice authority (e.g. expanded choice of practitioners, affordability, accessibility, improved quality of care).
2. Specification of the proposed change in practice authority, the practitioners to whom it applies (not necessarily all members of a profession or category of practitioners) and, if appropriate, any limitation as to qualifications, practice setting, or population to be served.
3. The duration of the proposed demonstration project.

#### ISSUE 4: Evidence Provided

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Establish that the applicant(s) will provide support for the contention that the health care practitioner is clinically competent to provide the proposed service(s). Evidence should include, but not be limited to, the following:

1. Identify other practice settings, states or nations where the proposed practice authority is already in effect.
2. Describe how the applicant group's formal educational curriculum provides the requisite clinical competence.

3. Describe how the applicant group has received additional training or other preparation to provide the proposed service(s).
4. Results from specified health care settings or systems (e.g. acute short stay hospitals, Indian Health Service, Veterans' Affairs Medical Centers, etc) where the proposed change in practice authority is already in effect.
5. Documentation from peer reviewed clinical or scientific literature or other original clinical outcomes evidence.
6. Identification of state or federal regulations authorizing or recognizing the proposed practice authority (e.g. reimbursement policy).

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#### ISSUE 5: Demonstration Project Design and Evaluation

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Describe the method by which the proposed demonstration project will be evaluated, including:

1. Study design (assurances for internal and external validity) and inclusion of a control group, practice setting or region, if appropriate.
2. Appropriate human subjects provisions.
3. Data to be gathered regarding the effect of the changed practice authority on access, quality of care, effectiveness, and costs.
4. Resources available to conduct evaluation.
5. Party (or parties) that will conduct the evaluation.

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#### ISSUE 6: Criteria for Evaluating Application

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In reviewing and deciding on whether to approve a proposed demonstration project, the oversight board or centralized agency should evaluate whether and how the proposed demonstration project will:

1. Have adequate funding to complete the demonstration project effectively.

2. Have any conflict of interest among the parties involved that may influence the results of the demonstration project. This includes any funding source (with a possible conflict of interest) that cannot be identified through traditional safeguards such as disclosure or project design elements.

The applications should also be evaluated to establish whether the proposed change in practice authority will:

1. Be a benefit to consumers.
2. Promote effective health outcomes.
3. Increase the public's access to a competent health care practitioner.
4. Assure that the public is protected from unsafe health care practices.

#### ISSUE 7: Liability Insurance Coverage

State law should provide that a health care professional, practicing within the context of an approved demonstration project, should be deemed to be acting within their scope of practice authority to assure that their acts and omissions are covered by professional liability insurance (if any is provided).

### Comprehensive Sunrise and Sunset Processes

Purpose of legislation: 1) To allow for “sunrise” review of proposals to change the practice authority of a profession or to create a newly regulated profession that establishes criteria, provides for public participation, and uses scientifically based decision-making. 2) To allow for “sunset” review of regulatory boards and/or the regulation of a profession that provides a mechanism for evaluation to assure that regulatory bodies are: operating in an effective and efficient manner; providing adequate consumer protection; and that the content of the regulation continues to protect the public.

#### ISSUE 1: Structure, Duties, and Powers

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Sunrise and sunset reviews, or administration by an oversight board or centralized agency, should:

1. Institute a process that allows the parties enough independence to make appropriate recommendations.
2. Assure under the process that decision-makers are not unduly influenced by politics.
3. Assure that the process considers the viewpoints of all affected parties, including the public.
4. Assure that the process has adequate budget and staffing.
5. Provide for enough time for review and completion of process.
6. Develop a reasonable schedule for review of regulatory programs.
7. Determine the disposition of the recommendations and legislative implementation.
8. Link sunset to sunrise when possible to provide coordination and consistency when reviewing regulatory programs, licensing, and scope of practice authority issues.
9. Coordinate sunset review with other oversight mechanisms such as the executive branch and the budget review process.

#### ISSUE 2: Evaluation Criteria for Sunrise Review

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Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument. Sunrise reviews should determine whether:

1. The change in the authority to practice provides a benefit to the public (choice, access, quality, or costs) without unreasonable risk.
2. The proposed regulation is flexible enough to accommodate changes in technology.
3. The public can reasonably be expected to benefit from an assurance of initial and continuing professional ability.
4. The public cannot be effectively protected by other means in a more cost-beneficial manner.

### ISSUE 3: Evaluation Criteria for Sunset Review

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Any sunset review of an existing professional board should determine whether:

1. Continued regulation by the regulatory body is necessary and, if so, whether it should be changed.
2. The education, experience, and testing requirements to ensure minimum competence, or whether they are overly restrictive and unduly limit competition between professionals, or whether they place undue burdens on those who want to enter the profession from within or outside the state.
3. The regulations have any deleterious economic impacts on practitioners, the public and the state's business.
4. The regulatory program provides accurate, timely and comprehensive information to the public about the qualifications and practice history of the licensed professional.
5. The practice authority of the regulated profession helps or hinders access to care.
6. The regulatory program encourages public participation in its policy development.
7. The regulatory program protects consumers against incompetent, negligent, fraudulent, or other illegal acts by licensed professionals or unlicensed persons posing as professionals.
8. The regulatory body performs its operations, programs and statutory duties efficiently, effectively and expeditiously.

### ISSUE 4: Performance Standards for Sunset Review

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In addition to the evaluation criteria listed above, any sunset review of an existing regulatory agency should:

1. Define performance standards for regulatory programs including appropriate budgetary expenditures, examinations, continuing competency, enforcement activity, aging of cases, consumer/complainant satisfaction, consumer outreach and education.
2. Establish periodic assessment of performance against established standards between formal sunset reviews.
3. Assure consistency among regulatory programs in the carrying out of their responsibilities.

**Recommendation 10**

States should require that their regulated health care practitioners demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their careers.

*See report text for a full discussion of this recommendation*

Purpose of legislation: To complement the existing system for assuring competence, such as mandatory continuing education with license renewal, the regulatory body should require an affirmative, periodic demonstration of continued competence in the regulated practitioner's area of practice. This legislation is not intended to require duplication of initial licensure requirements, but rather to ascertain and assure competence in the practitioner's chosen field of practice.

#### ISSUE 1: Define Continuing Competence

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The regulatory body should adopt and communicate to the regulated practitioners a definition of "continuing competence" which includes knowledge, judgment, technical and interpersonal skills, and ethics. Regulatory bodies should work with the professional education community so that all components of this definition are integrated into continuing education curricula and other avenues of satisfying the continuing competence requirement.

#### ISSUE 2: Periodic Review

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States should determine the necessary period (not to exceed seven years) for demonstration of continuing competence including:

1. Consideration of more frequent (less than seven years) required demonstrations for practitioners over a particular age, if part of an individualized remediation program, for particular specialties, for practitioners in isolated practice settings, or for others as deemed necessary.
2. For administrative ease, consideration of tying required competence demonstrations to license renewal period (e.g. every fourth renewal).

### ISSUE 3: Continuing Competency Requirements

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States should develop multiple alternative avenues of satisfying the continuing competence requirement. Alternative avenues should be formally evaluated for their effectiveness every three to five years. States should assure that the “interpersonal skills” or ethics competencies are integrated into all continuing competency mechanisms. These alternative avenues include, but are not limited to:

1. Initial license examination.
2. Reexamination in licensee’s area of specialty or practice focus (the area in which the practitioners holds him/herself out to the public).
3. Private professional or specialty board certification or re-certification (if the board is approved in advance by the regulatory body). Advance regulatory approval of any certification or re-certification process should be based on meeting objective criteria assuring that the organization’s evaluation of the practitioner is competency-focused.
4. Appropriate chart review, if possible, or through a peer review mechanism of actual practice approved in advance by the regulator and appropriate to the practitioner’s specialty. Chart or peer review may be delegated by the regulatory body to a private professional organization, utilizing standards and procedures approved by the regulatory body. Chart or peer reviewers should be trained and evaluated to assure consistency in review criteria and application of the criteria.
5. Successful completion of an approved residency, fellowship program, or other recognized training.
6. Supervised by the regulatory body, a comprehensive self-evaluation of continuing competence, identification of practice weaknesses, and tailored continuing education coursework with required examination or demonstration of comprehension of course material.

### ISSUE 4: Options for Remediation

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If a practitioner fails to provide required demonstration of continuing competence, states should require remedial education approved in advance by the regulatory body, with

follow-up peer review. Thereafter, the demonstration of continuing competence would be repeated. Further considerations include:

1. Competency demonstration is not intended to be a “short cut” or substitute for the traditional disciplinary process.
2. The regulatory body should work with professional education community to develop remedial programs and curricula.

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#### ISSUE 5: Strengthening and Improving Current Continuing Competence Mechanisms

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While the continuing competency demonstration requirements listed above will complement the current “marker system” system for detecting post-licensure incompetence and misconduct, the regulatory body should evaluate and enhance their ability to assess practitioner competence by strengthening and improving on current continuing education (CE) and reporting requirements. These current processes and how states might strengthen and improve them include:

1. License renewal process—periodic renewal process involving completion of a form, under penalty of perjury, requiring disclosure of reportable events (e.g. lawsuits, hospital investigations or discipline) and verification of completion of CE requirements.

*Options for strengthening and improving:*

- A. Tighten definitions of reportable events.
- B. Expand reporting requirements to include: hospital investigations and discipline; malpractice claims, payouts and settlements; criminal convictions; and other events deemed important by the state.
- C. Invest in data collection systems that quickly identify missing information and trigger its collection.
- D. Random audit of self-reported information for veracity; impose penalties for filing false application.



## 2. Completion of continuing education requirements

### *Options for strengthening and improving:*

- A. Restructure CE requirements so there is a needs assessment at one end, and an assessment at the other end (to ascertain comprehension of course material), so that the requirements are tailored to the individual (and focused on his or her specialty or current practice focus).
- B. Assess the number of hours required and determine whether the overall requirement is meaningful and enhances competence.

## 3. Hospital and other provider peer review and reporting of internal discipline to the regulator

### *Options for strengthening and improving:*

- A. Expand reporting requirement to have more reports beyond hospitals and managed care plans only (e.g. home health care agencies).
- B. Expand the reporting requirement to cover providers other than physicians.
- C. Require an affirmative annual “tax return”-type summary by all providers (e.g. hospitals, managed care plans, other health care facilities employing health care practitioners) of all actions taken against practitioners, even if zero.
- D. Substantially increase the penalty (fines) for failure to file required reports to deter noncompliance.

## 4. Medical malpractice insurance carrier reporting of claims, payouts and arbitration judgments to the regulatory body

### *Options for strengthening and improving:*

- A. Require insurance carrier to report every claim and every disposition (even if no payout).
- B. Create a remedy for noncompliance with reporting requirement through the state Insurance Commissioner or Department (e.g. automatic fine collected at time of company license renewal).

5 . Court clerk reporting of criminal convictions and pleas to the regulatory body

*Options for strengthening and improving:*

- A. Require health care practitioner defendants to inform courts that they are a health care practitioner subject to a reporting requirement.
- B. Require fingerprints of all licensees, so that arrested licensees can be reported to the regulatory body at point of arrest.
- C. Require prosecutors to report arrests and criminal convictions of health care practitioners to the regulatory body; require prosecutors to forward copies of preliminary hearing transcripts to the regulatory body (regulatory body can use evidence adduced at preliminary hearing in interim suspension or discipline hearing).
- D. Expand the reporting requirement to all non-physician health care providers.

6. Regulator and provider reporting to the National Practitioner Data Bank (NPDB)

Currently the NPDB is applicable only to MDs, DOs, dentists, and podiatrists.

*Options for strengthening and improving:*

States should collaborate to persuade the federal government to:

- A. Open the NPDB to the public.
- B. Require reporting to the NPDB to include pending matters (hospital disciplinary proceedings, medical malpractice proceedings, and pending licensing matters where charges are filed).
- C. Expand NPDB reporting to all other health care practitioners.

7 . Disciplinary system as a reactive mechanism to detect and address incompetence

*Options for strengthening and improving:*

- A. Require regulatory bodies to disclose the outcomes of closed complaints and make information regarding those complaints open to the public.
- B. Require disciplinary systems to accord quality of care and incompetence cases the same priority as other types of disciplinable conduct (e.g. drug and alcohol, criminal or sexual misconduct).

- C. Provide disciplinary systems sufficient resources to do their job.
  - D. Provide that all disciplinary actions or decisions be made public (with easy access via Internet, telephone or other media) so that the public can make informed decisions about practitioner competence.
  - E. In quality of care and incompetence cases, require the disciplinary system to include a focus on remedial education and clinical training to enhance competence. Also, authorize the regulatory body to, in appropriate quality of care and competence cases (even those where the practitioner is the subject of one complaint), to conduct “chart reviews” of the files of other patients undergoing the same or similar procedures.
8. Expanded use or implementation of “snitch laws” – akin to mandated reporting of child abuse, health care providers are required to report other health care providers they suspect to be incompetent or impaired. Failure to so report is a disciplinable violation; absolute immunity is granted for filing the report. States should not establish or strengthen “snitch laws” where the regulatory body has failed to or shows no signs of intending to enforce them. Failure to enforce them engenders lack of respect for legislative pronouncements and the body’s enforcement efforts.
9. Reporting by other government agencies (e.g. Food and Drug Administration, Drug Enforcement Agency, and Department of Health and Human Services) to the regulatory body – better coordination between professional review organizations (PROs) and state regulatory boards is a matter for federal legislation/regulation. This function is beyond the control of state legislatures and/or regulatory bodies.

## Activity shaping regulation since December 1995

With the release of the first Taskforce on Health Care Workforce Regulation's report in December 1995, the Taskforce staff dedicated the 1996 calendar year to discussing the issues and recommendations brought forth by the Commission and tracking regulatory activities across the country (Finocchio et. al., 1995). In addition to tracking regulatory activity and innovations, Taskforce staff also collected feedback from the field to the recommendations and policy options in the report through a speakers' bureau and by soliciting formal responses. A summary of the responses was published in a December 1997 document, *Considering the Future of Health Care Workforce Regulation: Responses from the Field to the Pew Health Professions Commission's December 1995 Report* (Gragnola and Stone, 1997). With increasing interest and activity surrounding regulatory issues, the UCSF Center for the Health Professions State Initiatives Program offered grant support to thirteen organizations, coalitions or individual researchers pursuing regulatory improvements in the areas of debate and discussion, planning and research.

The past two years have seen significant activity in professional regulation, including a wealth of debates and discussions, precedent-setting professional alliances and bold, new legislative proposals. This appendix attempts to capture these regulatory activities and innovations that have occurred in the ten recommendation areas identified by the Commission in 1995. The efforts described below have served to inform the Pew Health Professions Commission's continued dialogue regarding regulatory reforms.

### ISSUE 1: Standardizing Regulatory Terms

1995 Recommendation – *States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and the professions.*

Activity – Since 1995 there has been limited legislative or formal activity to standardize regulatory terms and language among states. National professional organizations have

discussed standardization of terms and considerable intra-professional activity has been reported. Nursing has been the most active, working in national or regional coalitions to standardize language regarding disciplinary terms, and delegation of responsibilities to unlicensed assistive personnel (Gagnola and Stone, 1997). Nursing, medicine, pharmacy, physical therapy, and physician assistants are also working within national professional coalitions to develop and promote the use of model practice acts that advocate a standardized approach to professional regulation.

In 1997, the Oregon legislature considered several bills that died in committee. Together, the bills would have standardized the size of health professions boards and their public membership, created an inter-professional oversight board, and standardized regulatory language and processes for all health professions within the state (OR H 2296, 1997; OR H 2293, 1997; OR H 2295, 1997; OR H 2294, 1997).

Efforts to standardize the complaints process in Arizona resulted in a law establishing the Health Professions Regulation Study Committee (AZ H 2029, 1997). The committee is developing a uniform complaint process, developing a plan to coordinate the various laws that govern the complaint investigation process, and determining how the boards can make the complaint process more efficient and cost-effective.

Partially supported by a grant from the University of California, San Francisco Center for the Health Professions, the Maine Health Professions Regulation Project recommended to the Governor and legislature that, “regulatory terms in Maine’s public law regulating health professionals should be standardized” (Kany and Janes, 1997). The project also recommended that Maine’s Department of Professional and Financial Regulation and regulatory boards pursue public policy for uniform state laws and endorsement. In addition, the National Council of State Boards of Nursing (NCSBN), as part of its grant from the UCSF Center for the Health Professions, has worked to develop a model for multi-state licensure. As part of this effort, the NCSBN compiled various data regarding issues of interstate practice especially concerning telenursing. The NCSBN has developed drafts of common requirements for licensure, including common language and mechanisms for cross-state discipline.

Other national professional associations continue to work toward various model laws that also serve to standardize regulatory language. Emerging professional models include telehealth and national hospital reporting requirements.

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#### ISSUE 2: Standardizing Entry-to-Practice Requirements

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*1995 Recommendation – States should standardize entry-to-practice requirements and limit them to competence assessments for health professions in order to facilitate the physical and professional mobility of the health professions.*

Activity – There were also efforts to standardize entry-to-practice requirements in the states. Activities focused mostly on establishing standards for newly regulated professions in the states. Thinking futuristically about standardizing entry-to-practice requirements, states are beginning to mandate statewide studies of regulation and regulatory processes. Florida’s H 1925 (1997), requires the appointment of a taskforce to develop uniform procedures to standardize the validation of health care practitioner credentials. Similarly, Nebraska’s NE L183 (1997) mandated a comprehensive study and evaluation of its credentialing system and development of a model credentialing process.

With the support of a University of California, San Francisco Center for the Health Professions grant, the National Black Nurses Foundation convened a meeting in February 1997 to discuss regulation and develop a consensus document. The participants supported a single, standard entry level for all nurses at the baccalaureate level (National Black Nurses Foundation, 1997).

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#### ISSUE 3: Removing Barriers to the Full Use of Competent Health Professionals

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*1995 Recommendation – States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different professions to share*

*overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the fullest extent of their current knowledge, training, experience and skills.*

Activity—There has been significant activity regarding scope of practice authority within the states and professional groups. The most visible has been legislative changes granting prescriptive authority or expanded practice authority for non-physician providers. Scopes of practice authority continue to be hotly debated among and within the professions. Of concern to health professions and professional boards, scope of practice battles are costly and time-consuming (Gagnola and Stone, 1997).

Scopes of practice authority saw more legislative activity than any other recommendation. Most expansions of scopes of practice were in the areas of prescriptive privileges and assignment of unsupervised tasks. Advance practice nurses, dental hygienists, physician assistants, and optometrists found fewer restrictions on their ability to practice independently.

Grantees of the University of California, San Francisco (UCSF) Center for the Health Professions also worked to improve scope of practice laws. The State University of New York conducted a study of optometry practice within a number of health plans (in Washington, Massachusetts, Pennsylvania, Wisconsin and Minnesota) where state optometric practice acts differ. The study examined differing practice, cost and quality patterns in relation to state practice laws and practitioner competency. Unexpectedly, the study found that some health plans did not allow optometrists therapeutic prescriptive authority, even though state law allowed it.

Eastern Virginia Medical School studied the current and projected practice scope of nurses and “new” providers such as unlicensed assistive personnel within Virginia’s integrated health care delivery systems. Study findings are intended to support the establishment of a demonstration authority in Virginia that would allow for scope of practice “demonstration waivers.”

The National Citizens’ Coalition for Nursing Home Reform built a consensus of support for specific legislative and administrative changes that would remove unnecessary barriers to the full use of competent health care providers in nursing homes (The National Citizens’

Coalition for Nursing Home Reform, 1998). The consensus statements will be used as the basis for model state legislation and recommendations for resolving scope of practice issues in the nursing home setting.

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#### ISSUE 4: Redesigning Board Structure and Function

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*1995 Recommendation – States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.*

Activity – There has been considerable activity within and among professions regarding board structure and function. Much of the activity has been by cooperative coalitions among professions such as the development of the Interprofessional Workgroup on Health Professions Regulation. This group of 15 different health professional associations began meeting in October 1995 to discuss regulatory issues and share information.

A few states have sought to formally improve board function and public accountability. In California, the Board of Vocational Nurses moved to a public member majority in 1997 (S 827), and the Board of Podiatric medicine proposed a public member majority in its 1997 Sunset review. In Florida, legislation was introduced that would have revised the make-up of five disciplinary boards (S 256, 1998). The new boards would have consisted of at least three consumer members and the rest would have been professional members. The function of these boards would have been to make a determination of the existence of probable cause in disciplinary cases and to advise the Secretary of the Department of Health on disciplinary matters.

In response to a solicited study of regulation in Virginia, the Board of Health Professions recommended to the Governor and the General Assembly that the board: provide the General Assembly with an opinion prior to any change in degree of regulation; regularly review scopes of practice regulation; and establish an advisory committee that includes non-traditional members (e.g. representatives of integrated health care delivery systems, employer purchasers,



and policymakers). The Board of Health Professions also recommended: seeking statutory authority for demonstration projects; establishing a mechanism for consistency and exchange among regulatory and policy entities within the state, especially in the area of telemedicine; and streamlining Virginia's entry-to-practice requirements with other states (Board of Health Professions of the Commonwealth of Virginia, 1998).

In addition to the 1997 Oregon effort (H 2293) to create a oversight authority mentioned in a section above, the Maine Project also proposed an inter-professional Federation of boards to serve in an advisory capacity and help improve inter-board communication and coordination (Kany and Janes, 1997).

In order to further study the influence of regulatory boards in health professions regulation, Professor Carol Weissert of Michigan State University received a UCSF Center for the Health Professions grant to conduct research of state medical boards as potential or actual agents of change in health professions regulation. The study also includes a 50-state survey of the structure, funding, political environment and policy activism of state medical boards and three case studies (Colorado, Maryland and Oregon) focusing on state boards that have been proactive in the policy arena (Weissert, 1997). The most policy activity among medical boards was reported in four areas: telemedicine, managed care, information for the public and alternative medicine.

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#### ISSUE 5: Informing the Public

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1995 Recommendation – *Boards should educate consumers to assist them in obtaining the information necessary to make decisions about practitioners and to improve the board's public accountability.*

Activity – While making information available to the public is strongly supported, the regulatory community often cites increased costs, time and effort as significant barriers (Gragnola and Stone, 1997). Massachusetts pioneered legislation allowing consumers access to physician profiles in 1995. Active since 1996, consumers can call the board for information

about a physician's education, specialties, hospital affiliations, disciplinary actions and malpractice settlements (Massachusetts General Law chapter 112 § 5, 1996).

In 1998, Idaho passed a "Patient Freedom of Information" law (S 1376). It requires disclosure of information about the practice and history of physicians and surgeons, osteopathic physicians and surgeons, physical therapists, dentists, podiatrists, chiropractors, optometric physicians, psychologists, physicians assistants, nurse practitioners and certified registered nurse anesthetists.

A law was enacted in Florida requiring the Department of Health to collect information to create physician profiles, with other licensed health care practitioners to be included by the year 2000 (S 948, 1997). Texas also enacted a measure mandating collection of provider information (S 805, 1997). California amended its physician and podiatric reporting requirements requiring disclosure of malpractice judgments, arbitration awards and hospital disciplinary actions resulting in termination or revocation of staff privileges (A 103, 1997). New Hampshire, Tennessee and Rhode Island each passed legislation to make information available to consumers (NH S 159, 1997; TN H 1786, 1997; RI H 6224, 1997).

Private companies have also begun to collect physician information making it available to consumers. MediNet, for example, provides information on any physician in the country as reported by their respective boards.

#### Web sites with information and research about licensed professionals and their boards

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Administrators in Medicine—<http://www.docboard.org>

- The health professional licensing database provided by the Administrators in Medicine and its participating boards. This site has links to medical boards in many states and contains over 450,000 licensed medical professionals.

Citizen Advocacy Center—<http://www.cacenter.org>

- The Citizen Advocacy Center in Washington, D.C. provides training, research, conferences and networking for health care institutions' public members and consumer representatives.

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Council on Licensure, Enforcement and Regulation (CLEAR)–<http://www.clearhq.org>

- CLEAR is an association of individuals, agencies and organizations, which comprise the international community of professional and occupational regulation dedicated to improving the quality and understanding of regulation in order to enhance public protection.

Federation of State Medical Boards–<http://www.fsmb.org>

- Considered the preeminent resource for board action information, the Board Action Data Bank is a central repository for formal actions taken against physicians by state licensing and disciplinary boards, Canadian licensing authorities, the U.S. armed forces, the U.S. Department of Health and Human Services, and other regulatory bodies. The Data Bank currently contains more than 70,000 actions related to approximately 25,000 physicians.

Massachusetts Board of Medicine–[http://www.docboard.org/ma/ma\\_home.htm](http://www.docboard.org/ma/ma_home.htm)

- The Massachusetts Physician Profiles offer a comprehensive look at over 27,000 physicians, licensed to practice medicine in Massachusetts. The information includes demographics of each physician's practice, education and training, awards received and participation in peer reviewed publications, disciplinary history and paid malpractice claims.

Medical Board of California–<http://www.medbd.ca.gov>

- Allows user to search physician licensee name, primary license status (if currently valid, revoked or suspended), licensee number and type, original license and expiration date, medical school attended and year of graduation.

National Association of Boards of Pharmacy's Pharmacist and Pharmacy Achievement and Discipline Database–<http://www.nabp.net>

- The Pharmacist and Pharmacy Achievement and Discipline Database (PPAD) contains information regarding disciplinary actions about pharmacists, interns, technicians, pharmacies and other entities licensed by State Boards of Pharmacy.

National Organization for Competency Assurance (NOCA)–<http://www.noca.org>

- The National Organization for Competency Assurance (NOCA) sets standards for credentialing organizations and serves its membership as a clearinghouse for information on the latest trends and issues of concern to practitioners and organizations focused on certification, licensure, and human resource development.

National Council of State Boards of Nursing–<http://www.ncsbn.org>

- The National Council of State Boards of Nursing is a not-for-profit organization whose membership is comprised of the boards of nursing in the 50 states, the District of Columbia, and five United States territories.

New York State Department of Health–<http://www.health.state.ny.us/nysdoh/opmc/main.htm>

- Information about professional misconduct and physician discipline.

Public Citizen–<http://www.publiccitizen.org>

- Health Research Group researches and publishes reports on physician discipline and other health related issues.

State of Vermont Medical Board DocFinder–<http://www.docboard.org/vt/df/vtsearch.htm>

- Allows user to search physician licensee name, primary license status (if currently valid, revoked or suspended), license number and type, original license and expiration date, medical school attended and year of graduation. Also includes disciplinary actions on file.

#### ISSUE 6: Collecting Data on the Health Professions

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1995 Recommendation – *Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.*

Activity – There was comparatively little activity in the area of data collection for support and planning for an effective health care workforce. As part of a larger study in multi-state licensing, the work of National Council of State Boards of Nursing compiled data regarding interstate practice. Two states attempted to use the legislative process to require health care workforce data collection. Nebraska's L183 (1997) mandated a comprehensive evaluation of the credentialing system and development of a model for streamlining the credentialing processes of health care practitioners, facilities and providers. Legislative efforts in Colorado failed when the Health Professions Workforce Information Bill (H 1094, 1997) died in the appropriations committee. The Colorado Health Professions Panel, however, has continued to build a Licensure Based Workforce Data System through public-private partnership efforts. As part of its UCSF Center for the Health Professions grant, the Panel is working with the University of Denver and the Colorado Department of Regulatory Agencies to voluntarily collect data on the health professions for the purposes of state workforce planning.

#### ISSUE 7: Assuring Practitioner Competence

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1995 Recommendation – *States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.*

Activity – Given the advances in technology and the expanding scopes of practice for many professions, most experts agree that competency should be reevaluated throughout a provider's career. In Canada, under Ontario's Regulated Health Professions Act, health professions boards were to implement a continuing competency program. The Board of Nursing program in Ontario requires the practitioner to do a self-assessment to identify

individual deficiencies to be further addressed through targeted education (The College of Nurses of Ontario, 1998). Similarly, the National Association of Boards of Pharmacy plans to implement the Pharmacist Applied Knowledge and Judgment Assessment, a voluntary self-assessment tool in 1999 (National Association of Boards of Pharmacy, 1998). In a statewide effort, the Washington State Department of Health convened an interdisciplinary workgroup to study mechanisms for instituting a continuing competency approach to health professions regulation with recommendations expected by early 1999 (Boruchowitz, 1998).

Noteworthy in the private sector is the continuing competence requirements of over 50 voluntary credentialing organizations (Citizens Advocacy Center, 1997). Examples from the professions include:

- National Commission of Certification of Physician Assistants (NCCPA) routine standardized testing of Physician Assistants in addition to continuing medical education requirements (Intergovernmental Health Policy Project, 1997);
- National Council of State Boards of Nursing's proposed use of Personal Accountability Profiles; and
- Federation of State Medical Boards (FSMB) calls for "time-limited certifications" to periodically reexamine physicians (Health Policy Tracking Service-Providers, 1997).

The FSMB and the National Board of Medical Examiners are also working towards using multiple mechanisms, such as computer based simulations, for evaluating post licensure competency of professionals (Health Policy Tracking Service-Issue Brief, 1997)

The Interprofessional Workgroup on Health Professions Regulation sponsored a Continued Competency Summit in July 1997; the Citizen's Advocacy Center held a conference in December 1996; and the Maine Project sponsored a November 1996 conference focusing on continued competency assessment. The Maine Project recommended that, "In addition to assuring minimum quality at the beginning of a career, each health professional regulatory board should establish requirements for continued competency"

(Kany and James 1997). In its May 1997 summit meeting, the American Academy of Nursing charged nurses with developing new methodologies for assessing individual, initial and ongoing competencies (American Academy of Nursing, 1997).

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#### ISSUE 8: Reforming the Professional Disciplinary Process

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1995 Recommendation – *States should maintain a fair, cost-effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.*

Activity – Health professions disciplinary processes are increasingly accessible to the consumer. Information regarding a physician's disciplinary history as well as complaint processes and filing are becoming more accessible via the Internet. The Administrators in Medicine, for example, has initiated a DocFinder database which has 14 medical boards participating as of June 1997 with several other states signing on (*see sidebar above*). In addition, the National Association of Boards of Pharmacy has put the first phase of its Pharmacist and Pharmacy Achievement and Discipline Database (PPAD) on-line for easy consumer access to disciplinary action information (*see sidebar above*).

Legislative action resulted in mandates for studying disciplinary processes in a handful of states. Oregon legislators requested the director of Administrative Services to study the feasibility of consolidating licensing, certification, registration, investigations and hearing processes related to professional occupations (Health Policy Tracking Service–Issue Brief, 1997). Florida also proposed the creation of a separate board for disciplining health care practitioners which would have had a majority of public members as well as a diverse group of professionals (S 256, 1998). Progress was also made in Arizona in 1997 when H 2029 was signed into law, mandating the study of the complaint processes and the development of a uniform complaint process.

The National Council of State Boards of Nursing has been looking at standardizing disciplinary processes with its work on multi-state licensing. Among the concerns of multi-state licensing is establishment of common language and mechanisms for cross-state discipline.

In addition, the National Citizens' Coalition for Nursing Home Reform developed consensus statements concerning regulatory issues for nursing homes. Policy issues discussed included accountability for regulation of health care workers and ongoing oversight and discipline of providers (National Citizens' Coalition for Nursing Home Reform, 1998).

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#### ISSUE 9: Evaluating Regulatory Effectiveness

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1995 Recommendation – *States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies in order to best protect and promote the public's health.*

Activity – Several projects were launched in the arena of broadly ensuring that health professions regulation protects and promotes public health. Virginia mandated a state-sponsored study to determine the need for regulation of any health care occupation or profession. The study, conducted by Eastern Virginia Medical School, recommended that the Board of Health Professions: increase public membership to 40 percent; give the Board more direct power to enforce decisions and recommendations; require any new professions wanting to be regulated to go through Board of Health Professions review (using a standard set of criteria); allow demonstrations or waivers for scope of practice challenges; and require continuing competency assurance (Final report to the Board of Health Professions, 1998).

As part of Governor Locke's regulatory reform effort, the Washington Department of Health will review all regulations over the next five years to determine if they are still relevant and effective (Washington State, Executive Order 97-02, 1997). Likewise, in Connecticut legislation was introduced (H 5614) in January 1997 that would have established a taskforce to reassess and streamline the regulatory structure of health professions and to address the issue of provider competency and access to health care. Connecticut's legislative session ended before action was taken on the measure.

## ISSUE 10: Understanding the Organizational Context of Health Care

### Professions Regulation

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*1995 Recommendation – States should understand the links, overlaps and conflicts between their health care workforce regulatory system and other systems which affect the education, regulation and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes.*

Activity – Legislative attempts at examining and changing the organizational context of health professions regulation were uncommon. In Oregon, however, the Assembly requested a study of the feasibility of consolidating licensing, certification, registration, investigations and hearing processes. From that request, the department issued a report, Regulated Professional Occupations, in January 1997. In addition, the Council on Licensure, Enforcement and Regulation (CLEAR) has held two symposia in Washington, DC to discuss the contexts of health professions regulation: Building Effective Partnerships for Professional Regulation Stakeholders, June 13-14, 1996, and Professional Regulation Stakeholders: The Second Symposium, June 2-3, 1997 (CLEAR, 1998).



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The Pew Health Professions Commission is a program of The Pew Charitable Trusts. The Pew Charitable Trusts support nonprofit activities in the areas of culture, education, the environment, health and human services, public policy and religion. Based in Philadelphia, the Trusts make strategic investments that encourage and support citizen participation in addressing critical issues and effecting social change. In 1997, with more than \$4.5 billion in assets, the Trusts awarded \$181 million to 320 nonprofit organizations.